No. 97-156-CFX Title: Randon Bragdon, Petitioner
v.
Sidney Abbott, et al.

Docketed: July 28, 1997 Court: United States Court of Appeals for the First Circuit

Entry	Date	Proceedings and Orders
	Jul 21 1997	Petition for writ of certiorari filed. (Response due August 27, 1997)
	Aug 15 1997	Brief amicus curiae of American Dental Association filed.
	Aug 18 1997	Waiver of right of respondent Maine Human Rights Commission to respond filed.
	Aug 27 1997	Waiver of right of respondent Sidney Abbott to respond filed.
	Sep 10 1997	DISTRIBUTED. September 29, 1997
	Sep 10 1997	Supplemental brief of petitioner filed.
	Sep 19 1997	Response requested.
	Oct 20 1997	Brief of respondent Sidney Abbott in opposition filed.
	Oct 20 1997	Letter from counsel for Maine Human Rights Commission received.
	Nov 3 1997	Reply brief of petitioner Randon Bragdon filed.
	Nov 5 1997	REDISTRIBUTED. November 26, 1997
	Nov 26 1997	Petition GRANTED. limited to Questions 1, 2, and 3 presented by the petition. The brief of petitioner is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m.,Friday, January 9, 1998. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, February 6, 1998. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, March 6, 1998. Rule 29.2 does not apply. SET FOR ARGUMENT March 30, 1998. **********
	Jan 7 1998	Joint appendix filed.
	Jan 7 1998	Brief of petitioner Randon Bragdon filed.
	Jan 8 1998	Brief amicus curiae of American Dental Association filed.
	Jan 9 1998	Brief amicus curiae of Equal Employment Advisory Council filed.
	Feb 4 1998	Brief of respondent Maine Human Rights Commission filed.
	Feb 6 1998	Brief of respondent Sidney Abbott filed.
	Feb 6 1998	Brief amicus curiae of United States filed.
	Feb 6 1998	Brief amicus curiae of Elizabeth Glaser Pediatric Aids Foundation filed.
	Feb 6 1998	Brief amici curiae of Aids Action Council, et al. filed.
	Feb 6 1998	Brief of American Medical Association filed.
	Feb 6 1998	Brief amici curiae of Infectious Diseases Society of America, et al. filed.
	Feb 6 1998	Brief amicus curiae of City of Los Angeles filed.
	Feb 6 1998	Brief amici curiae of Senators Harkin, et al. filed.
	Feb 11 1998	CIRCULATED.
	Feb 13 1998	Record filed.
	Feb 18 1998	Application (A97-628) for leave to file a reply brief on the

2 pp

No. 97-156-CFX

Entry	Date	Proceedings and Orders
		merits in excess of the page limits, submitted to Justice Souter.
	Feb 19 1998	Motion of Solicitor General for leave to parpticipate in oral argument as amicus curiae and for divided argument filed.
	Feb 19 1998	Application (A97-628) denied by Justice Souter.
	Mar 5 1998	Reply brief of petitioner Randon Bragdon filed.
	Mar 9 1998	Motion of Solicitor General for leave to parpticipate in oral argument as amicus curiae and for divided argument GRANTED.
	Mar 30 1998	ARGUED.
	Apr 3 1998	Record filed.

Supreme Court, U.S.
FILED

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OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT ET AL.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit.

PETITION FOR WRIT OF CERTIORARI

JOHN W. MCCARTHY, ESQUIRE
Counsel of Record
BRENT A. SINGER, ESQUIRE
RUDMAN & WINCHELL
Post Office Box 1401
84 Harlow Street
Bangor, Maine 04402-1401
Phone: (207) 947-4501
Attorneys for Petitioner

APPELLATE SERVICE: CURRY & TAYLOR (215) 241-9764

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QUESTIONS PRESENTED

1. Is reproduction a major life activity within the meaning of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101-12213?

2. Are asymptomatic individuals infected with HIV per se disabled within the meaning of the ADA?

3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedures on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?

4. What is the proper standard of judicial review under title III of the ADA of a private health care provider's judgment that the performance of certain invasive procedures in his office would pose a direct threat to the health or safety of others?

5. Did petitioner, Randon Bragdon, D.M.D., raise a genuine issue of fact for trial as to whether he was warranted in his judgment that the performance of certain invasive procedures on a patient in his office would have posed a direct threat to the health or safety of others?

LIST OF PARTIES

The parties below were plaintiff/appellee Sidney Abbott, plaintiff/appellee the Maine Human Rights Commission, intervenor United States of America, and defendant/appellant Randon Bragdon, D.M.D.

An amicus brief was filed by the Association of State and Territorial Health Officials, the American Public Health

Association, the Association of State and Territorial Dental Directors, the Rhode Island Department of Health, the Department of Public Health, Commonwealth of Massachusetts, and the Bureau of Health of the Maine Department of Human Services. The American Dental Association also filed an amicus brief.

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OPINIONS BELOW AND JURISDICTION

Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997) (1a-30a); 912 F. Supp. 580 (D. Me. 1995) (31a-65a).

The judgment of the United States Court of Appeals for the First Circuit was entered on March 5, 1997. Petitioner's petition for rehearing and suggestion for rehearing en banc were denied on April 22, 1997, Chief Judge Torruella, dissenting. (66a-67a) This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

RELEVANT STATUTES AND REGULATIONS

42 U.S.C. § 12102(2): "The term 'disability' means, with respect to an individual – (A) a physical or mental impairment that substantially limits one or more major life activities; (B) a record of such an impairment; or (C) being regarded as having such an impairment."

28 C.F.R. § 36.104: "The phrase major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

42 U.S.C. § 12182(b)(3): "**Specific Construction**. Nothing in this subchapter [title III of the ADA] shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."

28 C.F.R. § 36.208(c): "In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk."

STATEMENT OF THE CASE

On September 16, 1994, plaintiff Sidney Abbott arrived at the private dental office of defendant Randon Bragdon, D.M.D., in Bangor, Maine, for an appointment. On her patient registration form, Ms. Abbott indicated that she was infected with HIV, the virus that causes AIDS. People may be HIV-positive for many years without manifesting the set of symptoms commonly known as AIDS, and Ms. Abbott was asymptomatic at the time.

Ms. Abbott was brought into the treatment area and seated in a dental chair. Dr. Bragdon performed a diagnostic dental examination and discovered that Ms. Abbott had a cavity near the gum line on a back, lower tooth. (69a, ¶ 6)**1** He told Ms. Abbott that, pursuant to his infectious disease policy, he would not fill her cavity in his office, but would treat her in a hospital setting. Ms. Abbott said that she would think about it and get back to him. (80a)

Two months later, Ms. Abbott sued Dr. Bragdon in the United States District Court, District of Maine (the "District Court") for disability discrimination under title III of the ADA. Title III prohibits disability discrimination by private entities

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1 This is a reference to paragraph 6 of page 69a of the appendix to this petition. Similar references follow throughout this petition.

in places of public accommodation. The District Court had jurisdiction pursuant to 28 U.S.C. § 1331.

Ms. Abbott argued that she was disabled because she was substantially limited in the major life activity of reproduction, and that asymptomatic HIV infection is per se a disability. Dr. Bragdon argued to the contrary. Dr. Bragdon also argued that even if Ms. Abbott were disabled, he was under no legal obligation to fill Ms. Abbott's cavity in his office because, in his judgment, the invasive procedures necessary to fill her cavity in his office would have posed a direct threat to the health and safety of others, including himself. The District Court acknowledged that the "position taken by [Dr. Bragdon] is not an unreasonable one" (63a), but it nevertheless granted summary judgment in favor of Ms. Abbott. Dr. Bragdon appealed.

The United States Court of Appeals for the First Circuit (the "Appeals Court") recognized the conflict among the circuits on the question of whether reproduction is a major life activity. The Appeals Court explained that "the question is very close," but it decided that "[r]eproduction (and the bundle of activities that it encompasses) constitutes a major life activity [under the ADA]." (11a) The Appeals Court also added a "final observation" implying that it was prepared to follow other courts in holding that all individuals infected with HIV are per se disabled under the ADA. (15a) This conflicts with the Fourth Circuit, which has expressly rejected the view that "HIV-positive status is per se a disability." Ennis v. National Ass'n of Bus. & Educ. Radio, Inc., 53 F.3d 55, 60 (4th Cir. 1995); see also School Bd. of Nassau County v. Arline, 480 U.S. 273, 289-293 (1987) (Rehnquist, C.J., & Scalia, J., dissenting) (tuberculosis, a contagious disease, is not a handicap within the meaning of the Rehabilitation Act of 1973).**2**

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2 The definition of "individual with a disability" under the ADA

With respect to the issue of direct threat, this case presents an issue expressly left undecided in Arline, namely, whether courts should defer to the reasonable medical judgments of private physicians as to the significance of the risk of communicating an infectious disease. Arline, 480 U.S. at 288 n.18. Dr. Bragdon argued that courts should defer to private health care providers' judgments, as long as they are reasonable in light of then-current medical knowledge. (19a-20a) The Appeals Court disagreed. It granted a continuing presumption of correctness to conclusions which it said "seem to be implicit" (23a) in 1993 Guidelines issued by the United States Centers for Disease Control and Prevention (CDC). The seemingly implicit conclusions identified by the Appeals Court are that no further risk-reduction measures are desirable for dental workers when treating HIV infected patients than those measures recommended for all patients in the 1993 Guidelines, and that filling cavities of patients known to be infected with HIV is generally safe.

After reviewing the record, the Appeals Court decided that Dr. Bragdon did not raise a genuine issue of fact by presenting sufficient countervailing evidence to rebut the presumption of correctness attached to the seemingly implicit CDC conclusions. By a vote of five to one (Chief Judge Torruella, dissenting), the First Circuit denied Dr. Bragdon's petition for rehearing and suggestion for rehearing en banc. (66a-67a)

REASONS FOR GRANTING THE WRIT

is the same as the definition of "individual with a handicap" under the Rehabilitation Act of 1973, except that the term "disability" now replaces the term "handicap" in both statutes. In transplanting this definition from the Rehabilitation Act to the ADA, Congress intended the retention of the original meaning. See 42 U.S.C. § 12201(a). Therefore, with respect to the issue of disability, this petition does not distinguish cases arising under the Rehabilitation Act.

I. BECAUSE THERE IS A CONFLICT AMONG THE CIRCUITS ON THE REOCCURRING QUESTION OF WHETHER REPRODUCTION IS A MAJOR LIFE ACTIVITY UNDER THE ADA, AND BECAUSE THIS QUESTION RAISES A SIGNIFICANT AND CHALLENGING PURE ISSUE OF LAW UNDER AN IMPORTANT CIVIL RIGHTS STATUTE, THE COURT SHOULD GRANT THIS PETITION.

A. There is a Clear Conflict Among the Circuits on the Reoccurring Legal Issue of Whether Reproduction is a Major Life Activity under the ADA.

Federal courts in the First, Third, Seventh, Ninth, and District of Columbia Circuits, have all held that reproduction is a major life activity,[3] whereas courts in the Fourth, Fifth, Sixth, and Eighth Circuits, have all held that reproduction is not a major life activity.[4]

The Court of Appeals for the First and Eighth Circuits are expressly in conflict. Compare Bragdon, 107 F.3d 934 (11a)

3 E.g., Abbott v. Bragdon, 107 F 3d 934 (1st Cir 1996); Pacourek v. Inland Steel Co., 916 F. Supp. 797, 804 (N.D. Ill. 1996); Erickson v. Board of Govs. Of State Colleges, 911 F. Supp. 316, 323 (N.D. Ill. 1995); Doe v. Kohn, Nast & Graf, P.C., 862 F. Supp. 1310, 1318-1320 (E.D. Pa. 1994); Doe v. District of Columbia, 796 F. Supp. 559, 568 (D. D.C. 1992); Cain v. Hyatt, 734 F. Supp. 671, 679 (E.D. Pa. 1990); Doe v. Dolton Elementary School Dist. No. 148, 694 F. Supp. 440, 444-45 (N.D. Ill. 1988); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1986); Bielicki v. City of Chicago, No. 97-C-1471, 1997 WL 260595 (N.D. Ill. 1997); Soodman v. Wildman, Harrold, Allen & Dixon, No. 95-C-3834, 1997 WL 106257 (N.D. Ill. 1997).

4 E.g., Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996); Cortes v. McDonald's Corp., 955 F. Supp. 541 (E.D. N.C. 1996); Zatarain v. WDSU-TV, Inc., 881 F. Supp. 240, 243 (E.D. La. 1995), aff'd,79 F.3d 1143 (5th Cir. 1996); Farmer v. National City Corp., No. C-2-94-966, 1996 WL 887478 (S.D. Ohio).

with Krauel, 95 F.3d at 677. The Court of Appeals for the Fifth Circuit has affirmed, without opinion, the position that reproduction is not a major life activity. See Zatarain, 881 F. Supp. 240, 243 (E.D. La. 1995), aff'd, 79 F.3d 1143 (5th Cir. 1996). The Court of Appeals for the Seventh Circuit has stated in dicta that reproduction is a major life activity. See McWright v. Alexander, 982 F.2d 222, 226-227 (7th Cir. 1992). The Court of Appeals for the Fourth Circuit has been understood as holding that reproduction is not a major life activity. See Cortes, 955 F. Supp. at 546.5

B. The Needless Perpetuation of Conflict and Uncertainty Among Courts Over the Legal Issue of Whether Reproduction is a Major Life Activity Under the ADA is Inefficient and Senseless, and Leads to a Justifiable Public Perception that the Application of the ADA is Fundamentally Unfair and Arbitrary.

Due to the present conflict among federal courts on whether reproduction is a major life activity under the ADA, the very same person (e.g., Ms. Abbott or Ms. Krauel, see 95 F.3d 674) protected by the ADA under the very same facts in, for example, Massachusetts, New Hampshire, Maine, and Illinois, would not be protected in South Dakota, Minnesota, Iowa, and Missouri. Likewise, the very same person liable for the very same actions in the former states, would not be liable in the latter states. This fundamental inconsistency causes a justifiable perception in all jurisdictions that the ADA is unfair and arbitrary in its application. A failure by the Court to decide whether reproduction is a major life activity will also cause needless inefficiency in jurisdictions, like the Second and Tenth Circuits, where the issue has not yet been decided.6

5 Courts in the Second Circuit have discussed whether reproduction is a major life activity, but have not decided the issue. E.g., Lehmuller v. Incorporated Village of Sag Harbor, 944 F. Supp. 1087 (E.D. N.Y. 1996); Alexandru v. Northeast Utilities Serv. Co., No. 3:95CV461, 1996 WL 684421 (D. Conn. 1996).

C. The Question of Whether Reproduction is a Major Life Activity is Especially Well-Suited for Review Because It is a Neatly Circumscribed and Typically Dispositive Issue of Law.

The Appeals Court admitted that "the question [of whether reproduction is a major life activity] is very close." (11a) On the one hand, as the Appeals Court explains, conceiving and raising children are extremely important activities in our society; Congress envisions a definition of "disability" beyond old-fashioned concepts of "handicap"; reproductive disorders are included among the regulation's roster of physical impairments; the regulation's enumeration of major life activities is not meant to be exclusive; and reproduction is not completely dissimilar to the regulation's

6 The record presents no other theory according to which Ms. Abbott might be disabled under the ADA, other than the theory that she is substantially limited in the major life activity of reproduction, or that HIV-infection is per se a disability under the ADA. Questions presented numbered one and two are therefore dispositive in this case. Ms. Abbott may argue, on the contrary, that she was "regarded" by Dr. Bragdon as disabled, perhaps because he regarded her as contagious. Merely being regarded as contagious does not make one disabled under the ADA. Instead, Ms. Abbott would have to prove that Dr. Bragdon regarded her as substantially limited in one or more major life activities. See 42 U.S.C. § 12102(2)(C); 28 C.F.R. App. B, § 36.104 (explaining that "regarded as having such an impairment" means "treated . . . as having a physical or mental impairment that substantially limits a major life activity"); Cook v. State of R.I., 10 F.3d 17, 25 (1st Cir. 1993) (exploring whether a jury properly could have concluded that defendant "regarded plaintiff's condition as substantially limiting one or more of her major life activities"); Harris v. Thigpen, 941 F.2d 1495, 1524 (11th Cir. 1991) (concluding that HIV-infected prisoners were handicapped because the prison regarded them as unable to engage in the major life activities of learning and working); Doe v. Centinela Hosp., No. CV 87-2514, 57 USLW 2034 (D. Cal. 1988) (HIV-infected individual regarded as substantially limited in the ability to learn). There is no evidence at all that Dr. Bragdon regarded Ms. Abbott as substantially limited in any major life activity, nor did Ms. Abbott argue below that Dr. Bragdon regarded her as substantially limited in any major life activity.

enumerated major life activities of performing manual tasks, walking, seeing, hearing, and so forth. See 28 C.F.R. § 36.104.

On the other hand, many healthy, intelligent, normal people choose never to have children, unlike frequent and necessary activities such as performing manual tasks, walking, seeing, hearing, and so forth. With respect to the major life activity of working, millions of Americans work every day, not as a lifestyle choice, but because they must earn a living. That is why working is included as a major life activity under the ADA. The same cannot be said for reproduction. In addition, viewed as a whole, the regulations indicate that the Attorney General did consider reproductive issues, see 28 C.F.R. App. B, § 36.104 (reproductive system disorders are impairments under ADA), and concluded that although reproductive disorders are "physical impairments," reproduction is not itself a major life activity, see 28 C.F.R. § 36.104. Activities such as eating and sleeping, which also are not on the regulation's list of major life activities, are much more analogous to activities on the list, than is reproduction.7

D. The Question of Whether Reproduction is a Major Life Activity is Sufficiently Important to Warrant the Attention of the Court.

Ms. Abbott may argue that although the issue of

7 By reviewing this issue, the Court may also want to provide some guidance, at least indirectly, on how courts should treat other potential candidates for major life activities, such as "interacting with others," and "caring for others." Compare EEOC Compliance Manual (CCH) § 902.3,¶ 6883, at 5311 (1995) (stating that interacting with others is a major life activity) and Dolton Elementary School, 694 F. Supp. at 444 (ability to interact with others is a major life activity) with Soileau v. Guilford of Maine, Inc., 105 F.3d 12 (1st Cir. 1997) (indicating that getting along with others, and interacting with others, are probably not major life activities) and Krauel, 95 F.3d at 677 (caring for others is not a major life activity).

whether reproduction is a major life activity has been reoccurring, and is likely to reoccur, it will not reoccur with sufficient frequency to warrant the attention of the Court. This is incorrect.

The incidence of infertility in countries like the United States is estimated at between 10% and 15%, or up to one in every six couples. (209a, 221a, 223a) Surveys show that there are approximately 4.9 million women between the ages of 15 and 44 in America who are infertile (221a), and who are thus "disabled" according to the First Circuit, but not the Eighth Circuit. Approximately $1 billion is spent annually by couples seeking to overcome infertility. (210a) The Court should therefore expect a significant increase in litigation under the ADA concerning conduct and/or accommodations of employers, employee benefit plans, and insurers toward individuals seeking and undergoing infertility treatments. See, e.g., Clapp v. Northern Cumberland Memorial Hosp., ___ F. Supp. ___ (D. Me. April 24, 1997) (ADA action by infertile woman alleging disability discrimination for denial of sick leave benefits); see also 42 U.S.C. § 12201(c); 29 C.F.R § 1630.4(e), (f); EEOC Interim Policy Guidance on ADA and Health Insurance (June 8, 1993).

Any doubts as to the importance of this issue are also substantially outweighed by the existing widespread conflict among federal courts, and by the fact that the issue is neatly circumscribed, ripe for review, and typically dispositive when it does arise. If the Court fails to decide this issue, it will also perpetuate needless and expensive uncertainty among ADA litigants and potential litigants, and contribute to a justifiable perception of fundamental unfairness in the application of the ADA.

II. BECAUSE THERE IS A CONFLICT AMONG THE CIRCUITS ON WHETHER ASYMPTOMATIC

INDIVIDUALS INFECTED WITH HIV ARE PER SE DISABLED, AND BECAUSE THIS IS A QUESTION OF THE UTMOST SIGNIFICANCE TO MANY MILLIONS OF AMERICANS, THE COURT SHOULD GRANT THIS PETITION.

A. Circuit Courts are in Conflict as to Whether Asymptomatic Individuals Infected With HIV are Per Se Disabled Under the ADA.

The Fourth Circuit has held that asymptomatic individuals infected with HIV are not per se disabled under the ADA.**8** The Ninth Circuit, and other courts, have held that asymptomatic individuals infected with HIV are per se disabled.**9** Some courts, recognizing that the wording of the ADA does not suggest that any physical impairment is, per se, a disability, have nevertheless concluded, in effect, that HIV infection is necessarily a disability because of its negative impact on the ability to procreate, or to interact with others.**10** In Arline, 480 U.S. at 282 n.7, this Court expressly left open the question of whether asymptomatic carriers of a virus such as HIV are disabled.

In this case, the Appeals Court found support for the

8 Ennis v. National Ass'n of Business & Educ. Radio, 53 F.3d 55, 59-60 (4th Cir. 1995); cf. also Runnebaum v. NationsBank of Md., N.A., 95 F.3d 1285, 1289 (4th Cir. 1996) (reaffirming that asymptomatic HIV is not a disability per se), reh'g en banc granted, opinion vacated (Dec. 3, 1996).

9 E.g., Gates v. Rowland, 39 F.3d 1439, 1446 (9th Cir. 1994); Cloutier v. Prudential Ins. Co. of America, ___ F. Supp. ___ (N.D. Cal. 1997); United States v. Morvant, 898 F. Supp. 1157, 1161 (E.D. La. 1995); Howe v. Hull, 873 F. Supp. 72, 78 (N.D. Ohio).

10 E.g., Kohn Nast & Graf, P.C., 862 F. Supp. at 1321; Cain, 734 F. Supp. at 679; Dolton Elementary School, 694 F. Supp. at 444-445. Support for this approach is found in various regulatory guidelines. E.g., 28 C.F.R. App. B, § 36.104; 29 C.F.R. App. § 1630.2(j) ("HIV infection [is] inherently substantially limiting").

view that HIV infection is per se a disability, in the legislative history of the ADA. (15a) The Appeals Court implies that on that basis alone, it would have held that Ms. Abbott is disabled. (15a-16a) By doing so it would have avoided the absurd result that if Ms. Abbott were, for example, 70 years old, and not limited by HIV in her ability to reproduce, then she would not have be protected under the ADA. Equally absurd is the fact that Ms. Abbott's inability to have children, which is purportedly the basis of her disability, played no role in Dr. Bragdon's decision to defer treatment outside his office. Cf. Hedberg v. Indiana Bell Tel. Co., Inc., 47 F.3d 928, 932 (7th Cir. 1995) (defendant not liable under ADA unless it knew of disability). Nevertheless, Dr. Bragdon was found liable for discriminating against Ms. Abbott "on the basis of disability." 42 U.S.C. § 12182(a). The decision of the Appeals Court is therefore fundamentally incoherent without the premise that HIV infection is the disability.**11**

B. Whether HIV Infection is Per Se a Disability is a Question of the Utmost Significance to Millions of Americans.

Ms. Abbott's experts in this case estimate that approximately 1,000,000 Americans are infected with HIV. Very many of these individuals are asymptomatic, and will fortunately remain asymptomatic for at least quite some time. It goes without saying that whether such asymptomatic persons are per se protected under the ADA from employment and public accommodation discrimination is a question of immense significance not only to them, but to their employers, to private owners of public accommodations, and to many, many others. (200a-201a) If the Court agrees that HIV

11 In addition, as previously noted, see note 6 supra, there is no other basis in the record that possibly supports a finding that Ms. Abbott is disabled, other than the theory that HIV infection is per se a disability, or the theory that Ms. Abbott is substantially limited in the ability to reproduce.

infection is per se a disability under the ADA, it would appear cruel beyond necessity for the Court, out of inchoate concerns for whether the issue is ripe for mature deliberation, to refuse to answer the question. If, on the other hand, the Court thinks that HIV infection is not per se a disability, then this is a case in which the courts of appeals are especially in need of guidance, as the weight of authority, except in the Fourth Circuit, is clearly that HIV infection is per se a disability.

C. By Deciding Whether HIV-Infection is Per Se a Disability, the Court Can Also Clarify a Significant Uncertainty as to the Role of Legislative History in Statutory Construction.

The ADA's legislative history reveals that many members of Congress thought, for whatever reason, that HIV infection would automatically be a disability; yet, the wording of the statute does not reflect it, and even suggests otherwise. The ADA itself was enacted after this Court left open in Arline, 480 U.S. at 282 n.7, the issue of whether asymptomatic carriers of a virus, such as HIV, are disabled. This is therefore an excellent opportunity for the Court to clarify for Congress and other courts the significance, if any, of legislative history, when such history seems inconsistent with the wording of the statute on a controversial political issue. In other words, perhaps lacking the votes in Congress to have expressly made HIV-infection a disability under the ADA, is it enough that legislative history may treat it as such?

III. THE COURT SHOULD REVIEW AND REVERSE THE APPEALS COURT'S DECISION ON THE ISSUE OF DIRECT THREAT, BECAUSE IT SETS A DANGEROUS, HIGHLY PUBLICIZED PRECEDENT, WHEREBY PRIVATE HEALTH CARE PROFESSIONALS WHO MAKE REASONABLE JUDGMENTS BASED ON THEN-CURRENT MEDICAL KNOWLEDGE MAY BE HELD LIABLE FOR CIVIL RIGHTS VIOLATIONS WITHOUT A TRIAL.

A. Dr. Bragdon Made a Reasonable Judgment, Based on Then-Current Medical Knowledge, that Filling Ms. Abbott's Cavity in His Office Would Have Posed a Direct Threat to the Health or Safety of Others.

The following sampling of facts in the record illustrate that, for purposes of summary judgment review, Dr. Bragdon raised a genuine issue of fact under 28 C.F.R. § 36.208(c), as to whether he made an objectively reasonable judgment, based on then-current medical knowledge, that filling Ms. Abbott's cavity in his office on September 16, 1994, would have posed a direct threat to the health or safety of others.[12]

1. In 1991, the Occupational Safety and Health Administration (OSHA) promulgated its Final Standard for Occupational Exposure to Bloodborne Pathogens, 56 Fed. Reg. 64004 (Dec. 6, 1991). These standards apply to dentists. See American Dental Ass'n v. Martin, 984 F.2d 823 (7th Cir. 1993), cert. denied, 114 S. Ct. 172 (1993). OSHA concluded that dental workers who have occupational exposure to blood or certain body fluids are "at risk" of contracting HIV, and that the rate of HIV infection is low, but "not insignificant." 56 Fed. Reg. at 64032. (81a-82a) OSHA specifically rejected the American Dental Association's contention that OSHA overestimated the occupational risk for dentists. Id. at 64092. (83a-84a) OSHA explained that empirical findings are compatible with a finding of a one in 1,000 risk to dentists of a

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12 For purposes of summary judgment review, "the evidence of the nonmovant [i.e., Dr. Bragdon] is to be believed, and all justifiable inferences are to be drawn in his favor." Anderson v. Liberty Lobby, Inc.,477 U.S. 242, 255 (1986). "Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, whether he is ruling on a motion for summary judgment or for directed verdict." Id.

fatal illness as a result of occupational exposure to HIV infected blood, and that such a risk has "clearly [been] defined . . . as a significant risk." Id. OSHA therefore requires, and the CDC recommends, the taking of certain "universal precautions" (gloves, masks, handwashing, etc.). They are called "universal" in the sense that they are to be used for all patients, not in the sense that they eliminate the risk to dentists of contracting HIV. In fact, when Senator Daniel Moynihan inquired of the CDC in 1995 as to the efficacy for dentists of taking "universal precautions," the Director of the CDC referred Senator Moynihan to "the two latest articles" on the subject. (85a-86a) The first article concerned only cutaneous exposures to blood, and reported an approximately 50% reduction by taking universal precautions. (225a) The second considered parenteral exposures as well, and concluded that "the implementation of UPs [i.e., universal precautions] should reduce the risk of occupational HIV infection by . . .62%." (89a)

This means that according to OSHA, evidence indicates that Dr. Bragdon and his assistants have a significant risk of contracting HIV without taking universal precautions. According to the latest studies recognized by the CDC, Dr. Bragdon and his assistants reduce that risk by 62% -- a little over half -- by taking universal precautions. Most reasonable minds would agree that a 62% reduction in a significant risk of contracting HIV still leaves a significant risk. Accordingly, Dr. Bragdon made a reasonable judgment, based on then-current medical knowledge, that the performance of an invasive procedure, such as filling Ms. Abbott's cavity near the gum line, would have posed a direct threat pursuant to 28 C.F.R. § 36.208(c).

2. In 1992, the Food and Drug Administration (FDA) issued recommendations for the prevention of HIV transmission. The FDA recommends a twelve month deferral

period for all potential blood donors "who have had contact with blood and body fluids through percutaneous inoculation (such as injury or accidental needlestick) or through contact with an open wound, non-intact skin, or mucous membrane during the preceding 12 months." (97a, 90a) This means that whenever a dentist has contact with any patient's blood by accidental needlestick or other sharps injury, the FDA, on account of concern for the transmission of HIV, recommends that the dentist not be permitted to donate blood for twelve months, to ensure that blood tests will detect HIV-antibodies if he is infected.**13** It is therefore reasonable to infer that the FDA, like OSHA, thinks there is a significant risk to dentists of contracting HIV when they are exposed to the blood of their patients.

Every time Dr. Bragdon fills a cavity such as Ms. Abbott's, there is a significant opportunity for him to be exposed to his patient's blood. See 56 Fed. Reg. at 64092 (82a) ("Dentists . . . are continually exposed to blood and bloody saliva during almost all dental procedures."). For example, during the injection of local anesthetic, accidental needlestick injuries to Dr. Bragdon occur before, between, and after injections, as a result of unexpected patient movements, such as biting down or flinching. (69a, ¶ 7; 77a-78a; 138a-139a; 176a) One of Ms. Abbott's experts testified that, for dentists, 1.5 accidental needlesticks per 100 injections, is a reasonable approximation. (154a-155a, ¶ 16) A startled patient can cause instruments, such as explorers (the "shepherd's crook" used to examine teeth), to be driven into the bone of the dentist's finger. (77a, ¶ 7; 139a) The CDC reports that during routine dental procedures, "contamination of saliva with blood is predictable [and] trauma to health-care workers' hands is common." MMWR, vol. 37, no. 24, p. 379

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13 Blood tests used to determine if someone is HIV-positive actually detect the presence of HIV-antibodies, which typically do not develop until one to six months after infection.

(June 24, 1988). Dr. Bragdon testified that even doing his best to implement universal precautions, he sustains sharps injuries, most of which draw blood, at the rate of several times a week. (99a-100a) In one study, thirty-five percent of dentists reported between two and fifteen sharps injuries per month. (125a) When drilling a cavity near the gum line, it is not unusual for splatters of blood to reach the dentist. (70a, ¶ 9;102a) The drilling process itself creates an aerosol mist of tiny droplets of blood and bloody saliva that drifts up into the face of the dentist. (69a-70a) Consequently, when filling cavities, and performing other so-called "routine" procedures, it is not at all unusual for the blood and mucous membranes of dentists to be exposed to the blood of their patients. (70a, ¶ 12, 72a-74a)

A reasonable inference from the FDA recommendations concerning deferral periods following exposure to a patient's blood, and from the likelihood of Dr. Bragdon being exposed to the blood of a patient when filling a cavity near the gum line, is that there was a direct threat to Dr. Bragdon within the meaning of 28 C.F.R. § 36.208(c).

3. In June 1994, the CDC reported thirty-seven confirmed cases of occupational transmission of HIV to health care workers (including four to non-surgical physicians), and seventy-eight suspected occupational transmissions of HIV to health care workers, including seven suspected occupational transmissions of HIV to dental workers. (104a-107a) The seven suspected occupational transmissions of HIV to dental workers are cases in which it is reasonable to infer that transmission occurred, because the dental workers suffered occupational exposures to HIV-infected blood, and follow-up investigation by the CDC uncovered no non-occupational risk factors for the HIV-infected workers. (105a) In other words, the seven dental workers who were infected with HIV were "investigated and are without identifiable [non-occupational]

behavioral or transfusion risks." (110a n.3; 111a n.3) The CDC does not, however, refer to such cases as "confirmed," because unlike the thirty-seven confirmed cases of occupational transmission of HIV to health care workers, the infected dental workers did not have blood tests done at the time of exposure confirming that they were HIV-negative at that time. (Id.)**14**

Moreover, in the same June 1994 report, the CDC cautioned that its passive surveillance system for documenting occupational transmissions of HIV "most likely does not reflect the full extent of occupational transmissions," and that estimates are that "only 10% to 60% of percutaneous injuries are reported" (emphasis added). (105a) Based on this CDC report, it was reasonable for Dr. Bragdon to conclude that perhaps as many as seventy dental workers, and at least seven, had already suffered occupational transmissions of HIV, and therefore, there would have been a direct threat to him and his staff while performing invasive procedures on Ms. Abbott in his office.

4. In 1991, the CDC reported that a Florida dentist, despite using barrier precautions, transmitted HIV to five of his patients, between 1987 and 1989. (111a-1 - 130a) The routine procedures in question included restorative fillings, prophylaxes, and simple extractions. The CDC explained that

> [a]ll five patients received multiple injections

14 The Appeals Court dismissed the relevance of these seven infected dental workers by playing on the word "possible." Specifically, although the CDC refers to these suspected cases of HIV transmission as "possible" cases, it is obvious from the context of the CDC report that this does not mean "possible" in the sense that "anything is possible." In legal terminology, what the CDC calls "documented" cases, and what the Appeals Court and petitioner call "confirmed" cases, are on the order of "beyond a reasonable doubt," whereas "possible" cases are those in whichthe preponderance of the evidence suggests that occupational transmissions of HIV occurred.

> of local anesthetic, and a sharps injury during anesthetic administration could have resulted in contamination of the syringe apparatus with the dentist's blood. . . . A sharps injury could also result in direct contact of the dentist's blood with the patient's inflamed or nonintact oral tissues during the invasive procedures. Although the dentist began to routinely wear gloves in 1987, gloves do not prevent most injuries caused by sharp instruments.

(126a)

The CDC updated this study in 1993, and concluded that a sixth patient was also infected with HIV while receiving care from this dentist. Unlike the other patients, "this patient had neither dental extractions nor root canal therapy." (132a) Other than X-rays and a cleaning, there was only a single surface restorative filling (131a), just like the "routine procedure" at issue in this case.

In addition, experts agree that the risk of transmission of HIV from patient to dentist is greater than the risk of transmission of HIV from dentist to patient. For example, Dr. Molinari's article in the October 1993 issue of the Journal of the American Dental Association reports: "The risk of transmitting HIV from patient to HCW [health care worker] is much higher than the risk of transmitting from HCW to patient." (137a) Dr. Molinari later reiterated his view that "the danger is much greater for dentists and dental care workers than it is for patients" (emphasis added). (139a)

Given the documented transmissions of HIV from dentist to patients while filling a simple cavity and other "routine procedures," given that courts are in agreement that there is a direct threat to patients from HIV infected health

care workers, including dentists,[15] and given experts' opinion that the risk to dentists is much greater than the risk to patients, it was again reasonable for Dr. Bragdon, or anyone else, to conclude that filling Ms. Abbott's cavity near the gum line would have posed a direct threat to him and his staff.

5. Dr. Bragdon also introduced as evidence an affidavit from Leon Kelleher, D.D.S. Dr. Kelleher directs a group of seventeen dentists who treat over 100 HIV-positive patients in the Chicago area. Dr. Kelleher testified that their "standard operating procedure is to avoid the use of aerosol producing instrumentation [i.e., the dentist's high speed drill] in known HIV+ cases." (140a, 143a) According to Dr. Kelleher, "[p]atients on whom the use of the high speed handpiece [i.e., the drill] is unavoidable are done with high volume evacuation under laminar flow conditions with hood or full face protection and remote air source for the operator." (143a) Dr. Kelleher's group adopted its protocols because of the results of a 1991 study conducted by Drs. Johnson and Robinson at Stanford University School of Medicine. (Id.) Drs. Johnson and Robinson reported that infectious HIV can be isolated from aerosols generated from HIV infected blood, and concluded that

> dentists . . . should avoid techniques which generate such aerosols . . . with patients known to be infected with HIV. Where such procedures are unavoidable, personnel should consider using high efficiency filtration masks and systems for containing aerosols.

(149a)

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15 E.g., Bradley v. Universtiy of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S. Ct. 1071 (1994); Mauro v. Borgess Medical Ctr., 886 F. Supp. 1349 (W.D. Mich. 1995); Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991).

Rather than filling Ms. Abbott's cavity in his one-dentist office in the outskirts of Bangor, where such high efficiency filtration devices are not available, Dr. Bragdon wanted to defer treatment to a local hospital setting, where he had reason to believe they were available. (101a) This was a reasonable judgment by a health care professional. Yet, without a trial, and despite conflicting expert affidavit's (150a-159a), two courts have now determined as a matter of law that Dr. Bragdon unlawfully discriminated against Ms. Abbott. Now pending in District Court is Ms. Abbott's application as a prevailing party for attorneys fees and litigation expenses in the amount of $205,190.63. The fact that Dr. Bragdon may owe over $200,000 for wanting to take the same precautions as are routinely taken by dentists in big cities, and that federal courts are in effect compelling him to take risks at work that other dentists routinely do not, is truly Orwellian, and deserving of this Court's attention.

6. In affirming the summary judgment against Dr. Bragdon, the Appeals Court held that all of the evidence presented by Dr. Bragdon, taken individually and cumulatively,**16** did not raise a genuine issue for trial. The

16 Dr. Bragdon presented other compelling evidence as well. For example, he presented the direct affidavit testimony of Sanford F. Kuvin, M.S., M.D., D.T.M. & H. Dr. Kuvin, whose qualifications under Rule 702 as an expert witness on infectious diseases were not challenged , corroborated the sources of information already discussed, and concluded that there would have been a direct threat to Dr. Bragdon. (150a-160a) Dr. Kuvin also testified that according to CDC recommendations regarding the danger of tuberculosis ("TB"), dentists should decline to perform aerosol-generating procedures on an HIV-positive patient without high-efficiency particulate air filtration that was unavailable to Dr. Bragdon in his office. (152a-154a) Using a form of analysis recognized by the Fourth Circuit in Doe v. University of Md. Medical Sys. Corp., 50 F.3d 1261 (4th Cir. 1995), and empirical data available to Dr. Bragdon in 1994, Dr. Kuvin further testified that a conservative estimate of the risk that a dentist will receive at least one fatal, accidental needlestick, during 30 years of practice giving approximately one injection per working day to an HIV infected patient, is one in ten. (154a-156a) For the sake of comparison, the risk of sustaining a fatal, accidental needlestick, while giving just one injection to an HIV infected patient, is slightly greater than the risk of having a fatal parachute accident while skydiving. (161a-162a, 164a, 165a-166a)

Appeals Court arrived at this result, ostensibly, by attaching a continuing presumption of correctness to the conclusions that it thought were implicit in the 1993 Guidelines. This is what the 1993 Guidelines actually say:

> This document updates previously published CDC recommendations for infection-control practices for dentistry (1-3) and offers guidance for reducing the risks of disease transmission among dental health-care workers (DHCWs) and their patients. . . .
>
> . . .
>
> A set of infection-control strategies common to all health care delivery settings should reduce the risk of transmission of infectious diseases caused by bloodborne pathogens such as HBV and HIV. . . .
>
> . . .
>
> For both HBV and HIV, the precise event or events resulting in transmission of infection in the dental setting have not been determined; . . .
>
> . . .
>
> Additional information is needed for accurate assessment of factors that may increase the risk for transmission of bloodborne pathogens and other infectious agents in a dental setting.

(182a, 183a, 184a, 199a)

The Court will search in vain in the 1993 Guidelines (181a-199a) for any more definitive statement of the significance of the risk to dentists, or of the rationality or

legality of taking additional precautions while working on persons known to be HIV positive. In fact, although the plaintiffs vaunt the significance of the 1993 Guidelines, they did not cite in their appellate briefs a single word from that document. Nor, apart from two references in the United States' brief to a 1993 CDC article about the risk of occupational infection in operating and delivery room settings (also cited by Dr. Bragdon in his brief), did the United States, Ms. Abbott, or any of their health department amici, cite a single word from any published CDC source, or even a single word from any of their own published sources.

The outcome of this case was therefore determined by the application of an extraordinarily unusual standard of review at summary judgment, and not by the failure of Dr. Bragdon to present evidence, including direct expert witness testimony,**17** that would have otherwise entitled him to a trial under normal summary judgment principles. Cf. Doe v. Johnston, 476 N.W.2d 28, 31 (Iowa 1991) (materiality of risk was properly a jury question when conflicting expert testimony put risk of contracting HIV between 1/100,000 and 1/1,000,000); cf. also Carter v. Temple-Inland Forest Products Corp., 943 S.W.2d 221 (Tex. App. 1997) (reasonableness of party's fear of developing cancer was properly a jury question when the evidence was that the risk of developing cancer was between 1/100 to 1/500,000).**18**

B. Ironically, Dr. Bragdon, More Than Ms. Abbott,

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17 See note 16 supra.

18 Another clear indication that Dr. Bragdon would have survived summary judgment on normal summary judgment principles, is that while the Appeals Court did its best to discount, ignore, and belittle the evidence presented by Dr. Bragdon, it did not indicate that the outcome would have been the same under a standard of review more favorable to him. In light of how narrowly the Appeals Court attempted to write on the issue of direct threat, the Appeals Court surely would have added such a proviso if it thought it were true.

Must Confront Myth and Prejudice in this Case.

It is sometimes assumed that among the poorly educated, there is an irrational fear and prejudice that HIV is easily transmitted. Whether or not this is true, there is most certainly a myth and prejudice among the well educated, including those like ourselves who have had friends or relatives become infected with HIV or die of AIDS. The myth is that apart from activities like unprotected sex and sharing dirty needles, science has shown that the risk of transmission of HIV to be nil, even for dentists working with sharp instruments in bloody mouths. The prejudice is that dentists or doctors who think otherwise, or who want to take significant additional precautions when working with even small amounts of HIV infected blood, must be ignorant, homophobic, stigmatizing, cowardly unethical, and/or uncaring.

This myth and this prejudice is perfectly exemplified by a recent cover story on this case in the American Bar Association Journal, in which the author assumes and/or implies for his audience that there is clear scientific evidence of no significant risk to dentists. He writes:

> Although the evidence is to the contrary, dentists may perceive greater risks of contracting HIV by coming into contact with a patient's blood. A typical dental examination is a more invasive procedure than a routine physical exam and often draws blood, even during routine cleaning.

(207a - emphasis added) The author, of course, does not explain what is the "evidence to the contrary," or in what medical journal or CDC publication it can be found.

The vital point for the Court to understand is that no-where in the record has the CDC, any of Ms. Abbott's four experts, or any of the many amici public health organizations, been able to point to a single, scientific, reasoned analysis that was available to Dr. Bragdon, concluding that the risk to a dentist filling a cavity (or performing other procedures which routinely draw patients' blood) is insignificant, or that because of a crisis in the availability or cost of dental care for HIV-infected individuals, dentists must be compelled by federal law to perform invasive procedures in their offices on patients known to be infected with HIV, without taking significant precautions beyond those recommended by the CDC for all patients. There is no such analysis. It is a myth that there is, and this myth serves a political agenda, just as much as the myth that AIDS is a gay disease serves a differing political agenda.**19**

Ms. Abbott herself plays upon this myth by repeatedly making the fallacious argument that the risk to dentists is nil because, except for the seven suspected transmissions of HIV to dental workers documented by the CDC, and the six transmissions to dental patients also documented by the CDC, the CDC has never documented another case of HIV transmission in the estimated over "one billion dental procedures" performed by "250,000 other dentists" in this country in "the last fourteen years." (Appellee's Br. at 8)

But what kind of argument is this, when people can be

19 The morally righteous tone to the plaintiffs' political agenda is illustrated by the response of one of Ms. Abbott's experts to the question of whether Dr. Bragdon should be legally compelled to treat HIV-infected patients, assuming there is a substantial likelihood of a transmission of HIV to him or his staff once every 10 years, or even once every year. His answer was "Yes," "Life is a risk," "[T]here's obviously a risk, and I think he should provide services. I'm not saying when you provide services you provide it risk free and nothing happens. So the time frame makes no difference to me." (170a-171a)

HIV-positive for many years without knowing it, and the CDC admits that its passive surveillance system for documenting HIV transmissions to dentists underreports by as much as 90%? (105a)

Scientifically, the argument is specious, but rhetorically, it helps reinforce the myth that it is nigh unto impossible to transmit HIV, outside of unprotected sex and dirty needles. The truth is, however, a little drop of blood on an open wound or mucous membrane can transmit HIV, although in light of the cruelty of many in society to those with HIV, we prefer to ignore it.**20** But this does not mean that the government ought to be in the business of compelling private health care providers to act against their reasonable judgments, even if reasonable health care providers disagree about the significance of a risk.

C. The Appeals Court's Decision Sets a Very Bad Precedent that Will Have Deleterious Effects On Efforts to Build an Improved, Coherent Administrative System for the Regulation of Small But Significant Health Risks.

An expert in administrative law recently observed that "serious problems currently plague efforts to regulate small, but significant, risks to our health." Stephen Breyer, Breaking the Vicious Circle, 10 (Harvard Univ. Press 1993). The Appeals Court's opinion, if left to stand as law, will exacerbate those problems.

More precisely, this case is being watched carefully by state and national public health agencies and health care providers (180a), including, of course, the many national and state agencies and associations that filed amicus briefs in the

20 The CDC reports that "visible blood on device" is a significant factor for increasing the risk of HIV infection for a health-care worker following a percutaneous injury. MMWR, vol. 44, no. 50, p. 929-932 (Dec. 22, 1995).

Appeals Court. Yet, not a single one of these organizations referred the Appeals Court to any official published source in which any of them tried to analyze in an authoritative, scholarly fashion, the significance of the risk to dentists, and what, if any regulation, is necessary on account of it. That is why the Appeals Court was reduced in all honesty to relying on what it said merely "seem[ed] to be implicit" in the 1993 Guidelines, and a negative inference from the fact that no public health authority has said "it is unsafe" for dentists.**21** In effect, therefore, some CDC officials have thus far succeeded, with no meaningful regulatory analysis, to enact and to enforce a new legal standard whereby a private doctor or dentist shall no longer follow his or her own reasonable judgment as to the safety of performing invasive procedures in his or her office. According to this standard, the doctor or dentist must follow a majority rule and/or divine what merely seems to be implicit in non-committal agency guidelines. At the same time, the amici public health officials have learned that it is unnecessary to issue clearly reasoned policy directives through publicly accountable processes, in order to effectuate new and remarkable policy.

This manner of regulating is the complete antithesis of the carefully reasoned, scientifically based, multidisciplinary approach envisioned by the author of Breaking the Vicious Cycle. The "regulatory process" followed by the CDC in this case, which is to publish non-committal guidelines, and then to permit its officials to make ad hoc stronger claims in private civil litigation, does not engender trust and confidence, but only brings home a political reality to health care providers that it is pointless, and even illegal, for them to critically digest and apply for themselves official sources of information about HIV found in scientific journals and CDC reports. This

21 The Appeals Court apparently decided to overlook the official CDC reports relied upon by Drs. Kuvin and Bragdon, as well as OSHA's conclusion that there is evidence of a significant risk to dentists.

dangerous state of affairs should be scrutinized carefully by the Court.

D. The Issue of the Proper Standard of Review Under Title III of Private Health Care Providers' Determinations of Direct Threat is an Issue of Nationally Reoccurring Significance.

Ms. Abbott's experts estimate that approximately one million individuals in the United States are infected with HIV. Thousands of times, every day, health care providers of every sort face the prospect of being vilified if they take significant additional precautions (which may include the deferral of treatment to another time or to a different location) when treating a person known to be infected with HIV. (180a, 200a) Numerous federal cases have already been filed when health care providers would not treat an HIV-infected patient without significant additional precautions, e.g., Sharrow v. Bailey, 910 F. Supp. 187 (M.D. Pa. 1995) (one-day deferral of surgery in order to obtain protective suits for surgical staff), or apparently, would not treat a patient at all.**22** Surveys show that many more suits are likely to be filed. (205a-206a)**23** Patients and the medical community in every federal circuit deserve to know how the balance between them will be struck under the ADA. Will courts defer to reasonable judgments of private health care providers, even if public health organizations disagree? Or, if there is room for reasonable

22 E.g., A.R. v. Kogan, ___ F. Supp. ___ (N.D. Ill. May 29, 1997); Hoepfl v. Barlow, 906 F. Supp. 317 (E.D. Va. 1995); United States v. Morvant, 898 F. Supp. 1157 (E.D. La. 1995).

23 Law Professor Scott Burris of Temple University reports that there are "thousands and thousands of cases" of HIV-infected individuals experiencing what they think is discrimination by dentists. While some ofthese cases may in fact represent unlawful discrimination, many are probably cases in which dentists are making reasonable professional judgments based on current medical knowledge of how HIV can be transmitted during dental procedures. In any event, the magnitude of the issue is evident.

experts to disagree, do the views of public health organizations, such as the CDC, take precedence? And if so, must these views be based upon critical analyses found in official writings, or is it enough that they seem to be implicit, or are put forth for the first time in private civil litigation?

E. Neither Arline, the ADA, Regulations, nor legislative History, Suggests that Private Health Care Providers Should Be Held Liable for Making Reasonable Judgments Based On Then-Current Medical Knowledge.

In deciding that courts should "normally defer to the reasonable medical judgments of public health officials," the Court in Arline was undoubtedly sensitive to the issue of the proper role for the reasonable medical judgments of private health care providers. Arline, 480 U.S. at 288 n. 18 ("we do not address[] the question whether courts should also defer to the reasonable judgments of private physicians . . ."). This sensitivity suggests that the Court was concerned with preserving the exercise of reasonable professional judgment by private health care providers. The ADA itself contains no wording to suggest that Congress intended to abrogate the exercise of reasonable professional judgments by private health care providers, even when balancing the interests of disabled persons. The applicable regulation states that when "determining whether an individual poses a direct threat . . ., a public accommodation must make an individualized assessment, based on reasonable judgment . . . ." 28 C.F.R. § 36.208(c) (emphasis added). This seems literally to contemplate the exercise of reasonable professional judgment by private persons who provide public accommodations. The legislative history of the "direct threat" provision in title III of the ADA states that that "provision is identical to one added in the employment section [i.e., title I of the ADA], and the discussion of this issue there applies here as well." H.R. Rep.

No. 101-485(III) at 62 (1990), 1990 U.S.C.C.A.N. at 485. The discussion of the issue in the employment section states that the "Committee intends to codify the direct threat standard used by the Supreme Court in . . . Arline." Id. at 34, 1990 U.S.C.C.A.N. at 457. That brings the Court back to Arline, with nothing in this circle of authorities to suggest that a dentist may be liable under the ADA for making a reasonable judgment based on then-current medical knowledge.**24**

F. The Decision by the Appeals Court is Literally Dangerous as a Matter of Public Health Policy.

Dr. Bragdon's view, which was a matter of public record before this lawsuit began, is that Maine, like other places, should invest the resources necessary to maintain designated HIV/AIDS clinics which include comprehensive dental care.**25** (168a-169a) That way, in Dr. Bragdon's opinion, "[w]e can help provide the best possible dental care for HIV/AIDS patients while at the same time providing the maximum protection to the uninfected citizens of Maine." (169a)

Although anecdotal, there has already been a striking example of the danger of taking away the right of a professional to exercise reasonable judgment when treating a person known to be infected with HIV. Approximately one

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24 Ironically, the First Circuit has decided that the intent under the ADA to codify Arline suggests that the burden is on plaintiffs to show that they do not pose a direct threat. E.E.O.C. v. Amego, Inc., 110 F.3d 135, 143 (1st Cir. 1997). If the First Circuit is correct in Amego, then the decision in Abbott v. Bragdon conflicts with Arline, and the Court should review this case on that basis alone.

25 Cf. Lasser v. Rosa, 654 N.Y.S.2d 822, 823 (App. Div. 1997) (dentist who offered HIV infected plaintiff referral to clinic which specialized in the treatment of HIV positive patients, and who explained that in his professional judgment, these "clinics offered precautions and accommodations beyond the minimum standards prescribed by the [CDC]," was not liable for discrimination based on HIV status).

year ago, Dr. Bragdon was contacted by a dentist who was presented with an apparently asymptomatic patient infected with HIV. Dr. Bragdon nevertheless urged his colleague to take extra precautions by deferring treatment until additional medical tests could be conducted on the patient. Although Ms. Abbott's experts would argue that such precautions are unnecessary, it turned out that, unbeknown to this patient, the state of his immune system had recently deteriorated substantially, and according to the patient's doctor, if the dentist had simply done the dental work that day, it may well have been fatal. Many years ago, before Dr. Bragdon started dental school, he saved the life of a laboratory technician handling a deadly chemical warfare agent by insisting on the additional precaution of double gloving, when that was not the standard protocol. Even health care providers specifically preferred by HIV-infected patients take significant additional precautions to protect themselves.**26** Thus, in a literal sense, the Appeals Court opinion is dangerous to patients and to health care workers who will undoubtedly be discouraged from deferring non-emergency treatment to settings where maximum precautions may be taken.

Finally, it is important to note that the Appeals Court's argument in its footnote 4, that this case does not address the issue of whether it is illegal for dentists to take additional precautions, is logically mistaken, and distorts Dr. Bragdon's arguments below. Contrary to the Appeals Court's premises in footnote 4, Dr. Bragdon did not claim the right to deny entirely routine dental treatment to patients with HIV, and he did not argue that his offer to treat Ms. Abbott in a hospital was "gratuitous." Instead, Dr. Bragdon maintained that under the ADA, whether the risk in a hospital setting would have been significantly less is legally irrelevant, provided he made an objectively reasonable judgment that there would have been a direct threat in his office. He explained:

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26 See confidential document lodged with the Court.

It is Dr. Bragdon's view that, legally, he had no duty to fill the cavity in his office, and whether he had a legal duty to fill it in a hospital is irrelevant. Ethically, however, Dr. Bragdon believes that he had a duty to treat Ms. Abbott. He therefore offered to treat her in a hospital setting where he believed he could most fully mitigate the risk, and where he would be more confident and comfortable.

(Appellant's Br. at 36-37)

The Appeals Court's statement that it is not addressing the legality of additional precautions, which it added in an errata sheet issued the day after Dr. Bragdon's petition for rehearing was denied, is simply an attempt, like the final sentence of the opinion, to write more narrowly than the case deserves, and very much more narrowly than this case is being received by millions of Americans. For if Dr. Bragdon did not even manage to raise a genuine issue of direct threat, on what legal grounds are other health care providers able to justify the taking of any significant additional precautions with persons known to be infected with HIV, such as, for example, deferring treatment to specialized locations outside the office, deferring treatment in order to obtain temporary, specialized equipment in the office, or deferring treatment to special times and/or permanent locations inside the office?

CONCLUSION

WHEREFORE, Dr. Bragdon requests that the Court agree to review the questions presented in this case.

Respectfully submitted,

John W. McCarthy
RUDMAN & WINCHELL
84 Harlow Street/Bangor,Me 04402-1401

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 96-1643

SIDNEY ABBOTT, ET AL.,
Plaintiffs, Appellees,

v.

RANDON BRAGDON, D.M.D.,
Defendant, Appellant.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

[Hon. Morton A. Brody, U.S. District Judge]

Before

Selya, Circuit Judge,
Aldrich, Senior Circuit Judge,
and Stahl, Circuit Judge.

John W. McCarthy, with whom Brent A. Singer and Rudman & Winchell were on brief, for defendant.
Peter M. Sfikas, Mark S. Rubin and Jill A. Wolowitz on brief for American Dental Ass'n, amicus

curiae.

Bennett H. Klein and David G. Webbert, with whom Gay and Lesbian Advocates and Johnson, Webbert & Laubenstein were on brief, for plaintiff Sidney Abbott.

John E. Carnes, Commission Counsel, on brief for intervenor-plaintiff Maine Human Rights Commission.

Samuel R. Bagenstos, Attorney, U.S. Dept. of Justice, with whom Deval L. Patrick, Assistant Attorney General, and Jessica Dunsay Silver, Attorney, were on brief, for intervenor-plaintiff United States of America, amicus curiae.

Robert Greenwald and AIDS Action Committee on brief for R.I. Dept. of Pub. Health, Bureau of Health of the Me. Dept. of Human Servs., American Pub. Health Ass'n, Ass'n of State and Territorial Dental Dirs., and Ass'n of State and Territorial Health Officials, amici curiae.

Donna Levin on brief for Mass. Dept. of Pub. Health, amicus curiae.

March 5, 1997

SELYA, Circuit Judge. In this case of first impression, the district court granted summary judgment in favor of plaintiff-appellee Sidney Abbott, an HIV-positive woman, on her claim that defendant-appellant Randon Bragdon, a dentist, violated the Americans with Disabilities Act (the ADA) by refusing to treat her in his dental office.[1] Dr. Bragdon appeals.

[1] Though we write for simplicity's sake as if Ms. Abbott were the sole plaintiff, we note that the federal government and the Maine Human Rights Commission intervened as plaintiffs below. We note, too, that Ms. Abbott prevailed upon a parallel claim under the Maine Human Rights Act (MHRA), 5 Me. Rev. Stat. Ann. tit. 5, § 4592 (West 1989). Interpretation of both the ADA and the MHRA has "proceeded hand in hand," Soileau v. Guilford of Me., Inc., ___ F.3d ___, ___ (1st Cir. 1997) [No. 96-1796, slip op. at 6], and the parties here do not suggest any distinction between the two statutes that might affect this appeal. Consequently, we need not discuss the MHRA further.

Because we agree with the district court that Ms. Abbott is disabled within the purview of the ADA and that providing routine dental care to her (i.e., filling a cavity) would not have posed a direct threat to Dr. Bragdon's health or safety, we affirm.

I. BACKGROUND

The events giving rise to this litigation are straightforward. On September 16, 1994, Ms. Abbott arrived at Dr. Bragdon's office in Bangor, Maine for a scheduled appointment. On her patient registration form, she indicated that she was infected with the HIV virus. People may be HIV-positive for years without manifesting the set of symptoms commonly known as AIDS, and Ms. Abbott was asymptomatic at the time.

Dr. Bragdon performed a dental examination and discovered a cavity. He told Ms. Abbott that, pursuant to his infectious disease policy, he would not fill her cavity in his office, but would only treat her in a hospital setting. Though he would charge his regular fee, she would have to bear the additional cost of whatever the hospital charged for the use of its facilities. Ms. Abbott refused the offer and instead filed a complaint under the ADA. See 42 U.S.C. § 12182(a) (1994).

After pretrial discovery concluded, the

parties cross-moved for summary judgment. The district court ruled that Ms. Abbott was substantially limited in a major life activity (reproduction) and thus was disabled for purposes of the ADA. See Abbott v. Bragdon, 912 F. Supp. 580, 587 (D. Me. 1995). The court then concluded that the relatively routine treatment needed by Ms. Abbott could be delivered safely in Dr. Bragdon's office. See id. at 591. Consequently, the court granted Ms. Abbott's motion for summary judgment. See id. at 595-96. This appeal followed.

II. THE SUMMARY JUDGMENT STANDARD

The Civil Rules authorize federal courts to grant summary judgment only when "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). Confronted with a properly documented motion for brevis disposition, the nonmovant must establish the existence of a fact that is both genuine and material in order to ward off the entry of an adverse judgment. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986); Garside v. Osco Drug, Inc., 895 F.2d 46, 48 (1st Cir. 1990). Appellate review of the district court's award of summary judgment is plenary, and, in keeping with this standard, we are not wedded to the district court's rationale but may affirm on any alternative ground made manifest by the record. See Hachikian v. FDIC, 96 F.3d 502, 504 (1st Cir. 1996).

In assaying the record, we are guided by the same tenets that guided the lower court. Thus, we are duty bound to indulge all reasonable inferences in favor of the party opposing summary judgment. See id. This generous outlook notwithstanding, we must disregard improbable or overly attenuated inferences, unsupported conclusions, and rank speculation. See Smith v. F.W. Morse & Co., 76 F.3d 413, 428 (1st Cir. 1996);

Medina-Munoz v. R.J. Reynolds Tobacco Co., 896 F.2d 5, 8 (1st Cir. 1990).

III. THE QUESTION OF DISABILITY

The ADA sends a clear message to those who operate places of public accommodation: you may not discriminate against individuals in the full and equal enjoyment of services on the basis of a disability. See 42 U.S.C. § 12182(a). Although a dental office qualifies as a place of public accommodation, see id. § 12181(7)(F); see also 28 C.F.R. § 36.104 (1996), the ADA protects only disabled patients against discrimination, and any attempt to invoke the ADA against a practicing dentist must start with an investigation into the patient's status. We turn, then, to the question of whether Ms. Abbott, who was infected with HIV but was asymptomatic, had a disability cognizable under the ADA.

This question is first and foremost a question of statutory construction which we review de novo. See Strickland v. Commissioner, Me. Dept. of Human Servs., 96F.3d 542, 545 (1st Cir. 1996). In all such cases, we begin with the words of the statute, and we approach them with an understanding that our role is not to set public policy, but, rather, to discern the legislature's will. See, e.g., United States v. Gibbens, 25 F.3d 28, 33 (1st Cir. 1994).

A. The Plaintiff's Burden.

Disability is not a unitary concept under the ADA. Instead, the statute limns three subsets of disability, any one of which is sufficient to trigger the act's protections. In this regard, the ADA states:

> The term "disability" means, with respect to an individual – (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as

having such an impairment.

42 U.S.C. § 12102(2). This case, as Ms. Abbott postures it, implicates the first subset of the statutory definition.2 Thus, she must prove three things: first, that she has a "physical or mental impairment"; second, that this impairment adversely affects "a major life activity"; and third, that it does so to a significant extent (or, put more precisely, that the impairment "substantially limits" her ability to engage in the particular major life activity).

B. The Impairment.

The plaintiff easily clears the first hurdle. We hold unhesitatingly that HIV-positive status, simpliciter, whether symptomatic or asymptomatic, comprises a physical impairment under the ADA. Regulations issued by the Equal Employment Opportunity Commission (the EEOC) implementing Title III of the ADA explicitly support this conclusion, see 28 C.F.R. § 36.104 (1996) (stating that the phrase "physical impairment" includes HIV); judicial authority buttresses this conclusion, see, e.g., Gates v. Rowland, 39 F.3d 1439, 1446 (9th Cir. 1994); Doe v. Garrett, 903 F.2d 1455, 1459 (11th Cir. 1990), cert. denied, 499 U.S. 904 (1991); and Dr. Bragdon does not seriously advocate an antithetical view.

C. The Major Life Activity.

Moving to the second hurdle, Ms. Abbott cites reproduction as her affected major life activity. The court below accepted this asseveration. See Abbott, 912

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2 The United States asserts that Ms. Abbott also is disabled under the third subset because society commonly regards individuals who are infected with HIV as having substantially limiting impairments. See generally Cook v. State of R.I., Dep't of Mental Health, Retard. & Hosps., 10 F.3d 17 (1st Cir. 1993) (discussing application of the "regarded as" language). We need not reach this contention.

F. Supp. at 587. Dr. Bragdon's rebuttal is twofold. In the first place, he disputes that reproduction properly can be characterized as a major life activity. In the second place, he asserts that even if reproduction so qualifies in general, there is nonetheless an unresolved issue as to whether it qualifies in Ms. Abbott's particular case. We address each of these assertions.

1. Reproduction Writ Large. The question of whether reproduction in large constitutes a major life activity under the ADA is not free from doubt. The ADA itself does not define the term "major life activities," and the few available judicial precedents reveal divergent opinions. Compare Pacourek v. Inland Steel Co., 916 F. Supp. 797, 804 (N.D. Ill. 1996) (finding that reproduction is a major life activity) and Erickson v. Board of Govs. of State Colleges, 911 F. Supp. 316, 323 (N.D. Ill. 1995) (same) and Cain v. Hyatt, 734 F. Supp. 671, 679 (E.D. Pa. 1990) (same) with Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996) (holding that reproduction is not a major life activity) and Zatarain v. WDSU-TV, Inc., 881 F. Supp. 240, 243 (E.D. La. 1995) (same). Still, it is clear that Ms. Abbott's HIV-positive status has a profound impact upon her ability to engage in intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations. Our society has long recognized the fundamental importance of each element of this cluster of activities, and our jurisprudence reflects this bias. See, e.g., Stanley v. Illinois, 405 U.S. 645, 651 (1972) (terming the rights to conceive and raise children "essential," "basic civil rights," and rights that are "far more precious . . . than property rights") (citations and internal quotation marks omitted). Viewed against this backdrop, we think it is highly likely that Congress accorded comparable importance to these activities when it authored the ADA.

The statute's text appears to bear out this intuition. Because the term "major life activities" is not defined in the enactment, we are obliged to construe it in accordance with its natural (that is, ordinary) meaning. See Bailey v. United States, 116 S. Ct. 501, 506 (1995); Smith v. United States, 508 U.S. 223, 228 (1993). The Court haslooked to familiar dictionary definitions in similar situations. See, e.g., Bailey, 116 S. Ct. at 506; Smith, 508 U.S. at 229. Following that model here lends support to the classification of reproduction as a major life activity. The plain meaning of the word "major" denotes comparative importance. See, e.g., The American Heritage Dictionary of the English Language 1084 (3d ed. 1992) (listing "greater than others in importance or rank" as the initial definition of "major"); Webster's Ninth New Collegiate Dictionary 718 (1989) (defining "major" as "greater in dignity, rank, importance, or interest"). These definitions strongly suggest that the touchstone for determining an activity's inclusion under the statutory rubric is its significance – and reproduction, which is both the source of all life and one of life's most important activities, easily qualifies under that criterion.

The origins of the ADA's language reinforce this conclusion. Congress lifted the term "major life activities" from the Rehabilitation Act of 1973, which used it in defining an "individual with handicaps." See 29 U.S.C. § 706(8)(B) (1988). In that milieu, the term was accorded "a broad definition, one not limited to so-called `traditional handicaps.'" School Bd. of Nassau County v. Arline, 480 U.S. 273, 280 n.5 (1987). In transplanting this combination of words from the soil of the Rehabilitation Act to that of the ADA, Congress specifically directed retention of the original meaning. See 42 U.S.C. § 12201(a) (1994). Had Congress sought to confine the definition of disability narrowly, it

surely would have written new, more restrictive language instead of borrowing a descriptive phrase notable for its breadth. See Doe v. Kohn Nast & Graf, P.C., 862 F. Supp. 1310, 1320 (E.D. Pa. 1994). It would be wholly inconsistent with this history to hold that Congress did not envision reproduction as a major life activity.

In addition to the language of the ADA and the historical antecedents of that language, we are guided by the regulations, which define "major life activities" to "mean[ ] functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 36.104 (1996).3 As the regulation itself clearly indicates, this enumeration is not meant to be exclusive, and reproduction – one of the most natural of endeavors – fits comfortably within its sweep. Furthermore, the portion of the regulations which defines physical impairments to include physiological disorders affecting the reproductive system, 28 C.F.R. § 36.104 (1996), militates in favor of the same outcome. From the scope of the latter regulation, we deduce that its drafters considered reproduction to be a major life activity – otherwise, including reproductive disorders among the regulation's roster of physical impairments would not have made much sense. See Pacourek, 916 F. Supp. at 1404-05.

The appellant resists this conclusion. The regulation itself includes no general adage to aid courts in determining what constitutes a major life activity, and he

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3 This phraseology is copied verbatim from 45 C.F.R. § 84.3(j)(2)(ii) (1996), a regulation implementing the Rehabilitation Act of 1973. Because that regulation was drafted with congressional oversight and approval, see Arline, 480 U.S. at 279-80, the definition merits particular deference. See Consolidated Rail Corp. v. Darrone, 465 U.S. 624, 634 (1984).

invites us to adopt a limiting principle which will preclude a finding that reproduction qualifies. In his view, major life activities do not embody lifestyle choices, or, as he puts it, "activities that many people decide never to do." This proposition has a modicum of decisional support. See Krauel v. Iowa Methodist Med. Ctr., 915 F. Supp. 102, 106 n.1 (S.D. Iowa 1995) ("Some people choose not to have children, but all people care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, and work, unless a handicap or illness prevents them from doing so."), aff'd, 95 F.3d 674 (8th Cir. 1996). In addition, courts have used other formulations en route to concluding that reproduction is unlike the activities listed in the regulation and, therefore, not a major life activity. See, e.g., Krauel, 95 F.3d at 677 (emphasizing that the plaintiff "has the ability to care for herself, perform manual tasks, walk, see, hear, speak, breathe, learn, and work" and is therefore not disabled); Zatarain, 881 F. Supp. at 243 (distinguishing reproduction from major life activities based on frequency of performance).

We do not find any of these formulations persuasive. In Krauel, the Eighth Circuit did not go beyond the activities explicitly included in the regulation and thus effectively treated the list as exclusive, not illustrative. Since the plain language of the regulation counsels otherwise, we are disinclined to emulate that example. The approaches taken by the Zatarain court and the district court in Krauel are no more attractive; in contradistinction to those courts, we see no reason why an activity must be performed either frequently or universally before it can be classified as a major life activity. There is no evidence that Congress intended either frequency or universality to operate as a restriction on the definition of "major life activities." Indeed, the activities explicitly enumerated in the regulation are not

wholly characterized by frequency and universality; learning – even in a broad sense – is for many adults not a part of daily life, and work is certainly not universal (as the lives of some of the very rich and some of the very poor demonstrate). The view from the other end of the spectrum bolsters this conclusion; neither lack of frequency nor lack of universality diminishes the fundamental importance of conceiving, childbearing, and raising a family.

This leaves us with the bare bones of Dr. Bragdon's thesis: that reproduction cannot be considered a major life activity because it is at bottom a lifestyle choice. That emaciated argument lacks force. To treat reproduction as a lifestyle choice, and no more, is merely an exercise in semantics. Most acts that human beings perform – or refrain from performing – have elements of volition. Speaking is undoubtedly a major life activity, but there are those (say, monks who have taken vows of silence) who choose to eschew it.

Though the question is very close, we think it must be resolved favorably to Ms. Abbott. Reproduction (and the bundle of activities that it encompasses) constitutes a major life activity because of its singular importance to those who engage in it, both in terms of its significance in their lives and in terms of its relation to their day-to-day existence. Mindful of this reality, and honoring what we believe to be Congress' intent, we hold that reproduction is a major life activity within the meaning of the ADA.

2. Reproduction Writ Small. Dr. Bragdon's fallback position is that Ms. Abbott is not disabled within the purview of the ADA unless reproduction is a major life activity for her. He then endeavors to use this position to defeat summary judgment, maintaining that a fact finder, drawing

defendant-friendly inferences from the summary judgment record, would confront a genuine issue as to whether giving birth and raising a child is so important to Ms. Abbott as to constitute one of her major life activities.

The premise on which Dr. Bragdon's argument depends is of uncertain reliability. Though it is true that analysis under the first subset of the ADA's definition of disability – "a physical or mental impairment that substantially limits one or more of the major life activities of [the plaintiff]" – calls for an individualized inquiry into whether the plaintiff is disabled, see 29 C.F.R. Pt. 1630, App. § 1630.2(j) (1996) (noting in the context of the ADA's employment discrimination regulations that "[s]ome impairments may be disabling for particular individuals but not for others"); Katz v. City Metal Co., 87 F.3d 26, 32 (1st Cir. 1996); Ennis v. National Ass'n of Business & Educ. Radio, Inc., 53 F.3d 55, 59 (4th Cir. 1995), the need for this case-by-case analysis of disability does not necessarily require a corresponding case-by-case inquiry into the connection between the plaintiff and the major life activity. By way of example, it might be enough for a court to consider only whether a given impairment substantially limits a particular plaintiff without considering whether the activity is of particular import to her. Be that as it may, the question is not dispositive here (nor will it be in many cases), and the most efficient way to decide this appeal is simply to postpone a definitive answer and assume, favorably to the appellant, that a plaintiff claiming a disability under the ADA must show a nexus between her impairment and the major life activity that she asserts has been substantially limited.

Even accepting arguendo that reproduction is not a major life activity for one with no interest in bearing children, the determination of whether

reproduction is a major life activity in a particular case does not automatically become a jury question. Cf. Medina-Munoz, 896 F.2d at 8 (noting that even "elusive concepts such as motive or intent" sometimes can be decided on summary judgment). Here, drawing all reasonable inferences in the manner most helpful to Dr. Bragdon, a fact finder could reach no conclusion other than that reproduction, if a major life activity at all, constitutes such for Ms. Abbott. We explain briefly.

Ms. Abbott's testimony on this point is uncontradicted:

> I have made the decision after I tested positive [for HIV] not to have children because of the risk of infecting the child and the risk of impairing my own immune system, and also the fact that this baby probably wouldn't have a mother after a while.

Dr. Bragdon offers no substantial rebuttal to Ms. Abbott's assertion that HIV ended her consideration of having a family, but instead asks us to doubt her sincerity. In his most telling sortie, he stresses the fact that, during her deposition, Ms. Abbott replied "no" when asked, "Are you impaired in your ability to carry out any of your life functions by the fact that you are HIV positive?" We do not believe that a party's response to a question about "life functions" – a phrase not used in ordinary parlance to refer to reproduction – can fairly be read as a direct contradiction of her unequivocal statements about her reasons for not bearing children. Dr. Bragdon has offered no other evidence suggesting that, short of her HIV infection, Ms. Abbott would have elected to remain childless. In the absence of specific discrediting evidence, a party cannot derail summary judgment by the primitive expedient of insisting that his

opponent's evidence should be disbelieved. See Grubb v. KMS Patriots, L.P., 88 F.3d 1, 4 (1st Cir. 1996).

To say more at this point would be supererogatory. Because uncontradicted evidence establishes that reproduction is a major life activity for Ms. Abbott, the second element of her case is firmly in place.

D. The Limitation.

We turn now to the final hurdle that blocks Ms. Abbott's path. At this hurdle, the parties joust over whether Ms. Abbott's HIV infection substantially limits her major life activity of reproduction. Under the applicable regulation, a person's major life activity is "substantially limited" if it is "restricted as to the conditions, manner, or duration under which [it] can be performed in comparison to most people." 28 C.F.R. Pt. 36, App. B § 36.104 (1996). Dr. Bragdon concedes that an HIV-positive pregnant woman faces an approximately 25% risk of transmitting the virus to her child without AZT therapy and an 8% risk of viral transmission with such therapy. He strives to persuade us, however, that there is an unresolved issue, sufficient to preclude summary judgment, as to whether HIV substantially limits Ms. Abbott's reproductive activity. In other words, he claims that on the record sub judice, a jury reasonably could find that the stated degree of risk does not substantially limit this infected person's ability to reproduce.

We are unconvinced. No reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity. Cf., e.g., 29 C.F.R. Pt. 1630, App. § 1630.2(j) (1996) (stating in the ADA's employment discrimination regulations that "[o]ther impairments, however, such as HIV infection,

are inherently substantially limiting"). In addition, Ms. Abbott faces the unfortunate reality that even if she gives birth to a healthy child, she probably will not live long enough to complete the task of raising the child to adulthood. We thus hold that HIV-positive status is a physical impairment that substantially limits a fecund woman's major life activity of reproduction. Ms. Abbott therefore is disabled within the purview of the ADA.

We add a final observation. As we noted earlier, our mission in cases of statutory construction is to discern the legislature's intent. The result that we reach here comports with evidence in the legislative archives that Congress deemed HIV infected individuals to be disabled under the ADA. See H.R. Rep. No. 101 485(111), at 28 n.18 (i990), reprinted in 1990 U.S.C.C.A.N. 445, 451 n.18 ("Persons infected with the Human Immunodeficiency Virus are considered to have an impairment that substantially limits a major life activity, and thus are considered disabled under th[e] first test of the definition."). Moreover, the ADA's precursor, the Rehabilitation Act, had been construed by the Department of Justice (DOJ) to protect persons infected with HIV from discrimination; in enacting the ADA, Congress endorsed the DOJ's view, noting that "a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." H.R. Rep. No. 101-485(II), at 52, 1990 U.S.C.C.A.N. 303, 334; see also S. Rep. No. 101-116, at 22 (1989). This legislative history thus independently bolsters our conviction that Ms. Abbott is disabled under the ADA.

IV. THE DIRECT THREAT QUESTION

Under the ADA, a place of public accommodation must extend its services to all disabled

persons without reference to their disabilities, subject to certain carefully circumscribed exceptions. See 42 U.S.C. § 12182(a). By virtue of one such exception, a covered service provider need not deal with an individual who "poses a direct threat to the health or safety of others." 42 U.S.C. § 12182(b)(3). The term "direct threat" is defined by the statute; in this context it contemplates the existence of "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." Id.4

Dr. Bragdon seeks safe harbor under this exception, asserting that requiring him to treat Ms. Abbott would pose a direct threat to his health. His argument envisions that to fill Ms. Abbott's cavity, he would need to inject a local anesthetic into her mouth and drill the decayed tooth. These procedures, he says, create an undue risk of HIV transmission both through needlestick and through the spattering of blood and bloody saliva.

4 It is important to note that Dr. Bragdon does not argue that his offer to treat Ms. Abbott in a hospital setting is a practice modification that would eliminate the claimed threat to his health. He did not endeavor to prove in the court below that hospital treatment was significantly safer than office treatment, and he makes no such argument to us. He argues instead that he had no duty to treat her in his office and that his offer to treat her in a hospital was gratuitous (and, therefore, legally irrelevant). Dr. Bragdon claims the right to deny entirely routine dental treatment to patients with HIV, and his defense must stand or fall on the correctness vel non of that thesis. It is only that claim which we consider here. Thus, this case does not address whether it is illegal under the ADA for dentists to take additional precautions when treating HIV-infected patients.

A court's goal in conducting a direct threat analysis under the ADA is to achieve a responsible balance, protecting service providers and other places of accommodation from enforced exposure to unacceptable health and safety risks while at the same time protecting disabled individuals from discrimination that is rooted in prejudice or baseless fear. See Arline, 480 U.S. at 287. EEOC regulations drawn from the Court's seminal opinion in Arline guide this analysis:

In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

28 C.F.R. § 36.208(c) (1996); see also Arline, 480 U.S. at 287-88 (discussing essentially the same factors).

Of course, any inquiry along these lines depends in one sense on what information permissibly may be weighed in the balance and in another sense on the extent to which particular kinds of evidence should be assigned extra weight (or, perhaps, decretory significance). Thus, before evaluating the medical evidence proffered by the parties, we must determine (1) the relevancy, if any, of subsequent medical knowledge (that is, medical evidence not available in September 1994 when Dr. Bragdon refused to treat Ms. Abbott), and (2) the degree of deference, if any, due the judgments of public health officials.

A. The Evidentiary Time Line.

The first of these excursions need not detain us. The applicable regulations instruct that a judgment

on the presence or absence of a direct threat must be predicated on "current medical knowledge or on the best available objective evidence," 28 C.F.R. § 36.208(c) (1996) (emphasis supplied), and, hence, point unwaveringly toward confining medical evidence to that available at the time a dentist or other health-care professional refuses to treat. This principle – that neither the service provider nor the prospective recipient of the service may prove or disprove the direct threat defense by relying on medical evidence not available when treatment was refused – is sound policy. Under such a regime, the service provider retains the opportunity to prove that he made an appropriate determination of the existence of a direct threat based on the evidence available when he made the decision to withhold his services. This is sound policy because, while health-care providers can be expected to maintain a working knowledge of currently accepted thinking in their fields, they cannot be expected to anticipate either future scientific advances or the emerging wisdom of public health organizations. In short, by holding covered service providers to an objective standard featuring the best evidence available at the time they refuse to render treatment to disabled persons, the ADA holds the delicate balance between sometimes conflicting rights steady and true.

This approach is also scrupulously fair. To punish providers when they satisfy an objective standard based on the best evidence available at the time of their decisions would be to punish them for a lack of clairvoyance. By the same token, to hold providers harmless after they have refused treatment based on nothing more than unfounded trepidation would run at cross-purposes with the central theme of the ADA. Fundamental fairness insists that providers in such circumstances ought not to be entitled to rely on

subsequent understandings to shield them from the condign consequences of discriminatory conduct.5 Cf. McKennon v. Nashville Banner Pub. Co., 115 S.Ct. 879, 885 (1995) (holding that an employer in an employment discrimination case may not justify its conduct based on evidence that did not motivate it at the time of the employment decision); North Shore Univ. Hosp. v. Rosa, 657 N.E.2d 483, 486 (N.Y.1995) (evaluating conduct alleged to be discriminatory under state law based on accepted medical practice at the time of the alleged infraction).

B. The Degree of Deference.

The second threshold determination involves the degree of deference due the medical judgments of public health authorities. The government joins Ms. Abbott in arguing for a rule which, if embraced, would cede great deference to those authorities. They posit that, in the absence of dissent among public health authorities, a service provider should be bound to accept the expressed collective judgment of those authorities unless he can demonstrate that this judgment is medically unreasonable. In contrast, Dr. Bragdon asseverates that, at least in the case of a service provider who is himself a skilled professional (such as a doctor or dentist), a court

5 Few rules are without exception in extreme cases. One can conceive of situations in which, after a medical professional refused treatment but before trial, there might occur some medical breakthrough or stunning new CDC pronouncement that overwhelmingly vindicated the professional's fears. Especially because decisions in ADA cases have some forward-looking impact, we do not rule out the possibility that later occurring events might occasionally be pertinent. But nothing in the present record suggests any post hoc scientific revelation warranting a departure from the usual rule.

should defer to the provider's judgment, as long as it appears to have been reasonable in light of then-current medical knowledge.

The question of deference pivots on language in Arline, where Justice O'Connor, writing for the Court, stated that in making factual findings of the sort that are necessary to inform the inquiry into the existence vel non of a direct threat, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288. In crafting regulations applicable to the ADA, the EEOC treated this passage from Arline as gospel. See 28 C.F.R. Pt. 36, App. B § 36.208 (1996) (remarking that the direct threat regulations "codif[y] the standard first applied by the Supreme Court in [Arline]").

We agree that the deference due public health officials must flow from the quoted passage – but acknowledging the hegemony of Arline does not signal automatic victory for Ms. Abbott and the government. The "defer entirely" formulation that they urge upon us is totally unprecedented; we have found no case in which the views of public health authorities are treated with the solicitude that Ms. Abbott and the government invite. If adopted, this formulation would come close to making a consensus among public health authorities unchallengeable by other medical evidence and, consequently, unreviewable by the courts. Nothing in Arline demands such obsequious obeisance to public health authorities or indicates an intention on the Court's part to consign the medical judgments of private physicians to some evidentiary Siberia. Instead, the Court quite clearly left the details of deference for another day. See, e.g., Arline, 480 U.S. at 288 n.15 ("This case does not present, and we do not address, the question whether courts should also defer to the reasonable

medical judgments of private physicians . . . .").

Because we are unprepared to say that medical wisdom resides exclusively in public health authorities, we reject the idea of a conclusive presumption. The applicable regulations state that "[s]ources for medical knowledge include guidance from public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health." 28 C.F.R. Pt. 36, App. B § 36.208 (1996) (emphasis supplied). This list is plainly illustrative, not exhaustive, and the use of the verb "include" indicates to us that other sources of medical knowledge are within the pale. The statute, the suggestion implicit in the regulations, and the teachings of the Court are best synthesized by fashioning a rule which gives prima facie force to the views of public health authorities, but which permits a service provider to challenge those views based on contrary, properly supported opinions voiced by other recognized experts in the field (e.g., research studies published in peer-reviewed journals). Such a rule accords a meaningful degree of respect to the views of public health authorities, particularly when those views are unanimous. But the rule draws a distinction between respect and absolute capitulation. Under it, the conclusions of public health authorities may be rebutted by persuasive evidence adduced from other recognized experts in a given field.6

Treating the presumption of correctness

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6 In United States v. Jessup, 757 F.2d 378, 381-84 (1st Cir. 1985), then-Judge Breyer distinguished "bursting bubble" presumptions (which vanish when contrary evidence is introduced) from "intermediate" presumptions (which remain available for consideration by the fact finder even after contrary evidence is introduced). The presumption here is of the latter stripe.

which attaches to the collective judgment of public health authorities as rebuttable will not, as the government intimates, sabotage the statutory scheme. Because the test for the existence vel non of a direct threat remains an objective one, a service provider cannot successfully contradict an achieved consensus simply by proffering an unsupported opinion. This ensures that, despite the rebuttable nature of the presumption, the direct threat defense may not be used to mask prejudice or unfounded fears. Rather, to frame a genuine issue, an opposing view must be documented by competent countervailing evidence that is directly relevant. Speculative inferences, glancing statistics, unsupported conclusions, and ruminative surmise will not serve.

C. Applying the Standard.

We turn next to a review of the medical evidence that was available when Ms. Abbott visited Dr. Bragdon's office in September 1994. By then, both the United States Centers for Disease Control and Prevention (CDC) and the American Dental Association (the Association) had spoken to the issue of the health risk to dental workers from patients infected with HIV. The Association's 1991 Policy on AIDS, HIV Infection and the Practice of Dentistry stated that:

Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed.

In 1993, the CDC updated its earlier guidelines and specified a compendium of infection control procedures, known as the "universal precautions," for use by dental

workers treating HIV-positive patients. See CDC, Recommended Infection-Control Practices for Dentistry, 1993 (the Recommendations). The CDC took the position that, when implemented, the prescribed precautions "should reduce the risk of disease transmission in the dental environment." Id. at 3. While the guidelines do not state explicitly that no further risk-reduction measures are desirable or that routine dental care for HIV-positive individuals is safe, those two conclusions seem to be implicit in the guidelines' detailed delineation of procedures for office treatment of HIV-positive patients. See United States v. Morvant, 898 F. Supp. 1157, 1166 (E.D. La. 1995) (concluding that "the universal precautions as prescribed by the CDC are universally accepted as `reasonable modifications' of practices that will significantly mitigate the risk [of HIV transmission from patient to dentist]").7 Tellingly, no public health authority has suggested that it is unsafe to provide routine dental care to HIV-positive patients in a private office environment. We find, therefore, that Ms.

7 In support of her motion for brevis disposition, Ms. Abbott also presented testimony from Dr. Donald Wayne Marianos, director of the Division of Oral Health at the CDC. Dr. Marianos stated categorically that "[n]o infection control procedures beyond the use of universal precautions are necessary when providing routine dental care to persons with HIV and AIDS." He also declared that "[t]he CDC does not recommend the use of infection control procedures beyond those cited in [the Recommendations] for the provision of routine dental treatment to persons with HIV or AIDS" and that "the risk of HIV transmission from patient to provider [in such circumstances] is so low as to be unquantifiable." Dr. Marianos' testimony is of limited value to us in assessing the medical evidence available to Dr. Bragdon inasmuch as the record contains no evidence that the CDC had publicly taken so explicit a position as of September 1994.

Abbott adduced competent evidence of reasonable medical judgments by public health officials, not contradicted by other public health authorities, to the effect that affording routine dental care (such as filling cavities) to HIV-infected patients in an office environment does not pose a direct threat to the dentist's health.

The next question is whether Dr. Bragdon has produced sufficient countervailing evidence that filling Ms. Abbott's cavity in an office setting would have constituted a direct threat to his health. In an endeavor to create a genuine issue of material fact, he cites eight sources of information which he argues show that rendering the necessary treatment in his office would have jeopardized his health.8 We examine these sources to determine if any of them, individually or in the aggregate, justify denying summary judgment to Ms. Abbott.

1. Dr. Bragdon notes that the Food and Drug Administration (the FDA) recommended in 1992 that persons who have had contact with a patient's blood through needlestick, non-intact skin, or mucous membranes refrain from donating blood for a year. This recommendation is clearly insufficient to demonstrate a direct threat to Dr. Bragdon. To safeguard the integrity of the blood supply, the FDA may seek to avoid minute

8 Although Dr. Bragdon presented material from a retained expert, Dr. Sanford Kuvin, he does not claim that Dr. Kuvin's testimony was based on medical knowledge available to him on the date he declined to treat Ms. Abbott, and his brief discusses Dr. Kuvin's testimony in a separate section devoted to the possibility that evidence available after September of 1994 might be relevant to the issue. To clinch the point, Dr. Kuvin's testimony itself relies on a number of sources not available until 1995 and beyond.

risks and take unusual precautions even in the absence of actual evidence of danger. It is not surprising, therefore, that the FDA issued its recommendation without making any finding that there was a significant risk of contracting HIV from contact of the type and kind described. In contrast, to determine whether there is a direct threat within the purview of the ADA, an inquiring court must gauge the nature, duration, and severity of the risk.9 The FDA's recommendation does not advance this inquiry.

2. Dr. Bragdon refers to a CDC report documenting forty-two incidents of transmission of HIV to health-care workers and seven possible transmissions to dental workers. We deem this data insufficient to warrant depriving Ms. Abbott of summary judgment. Evidence of HIV transmission to health-care workers outside the dental field does not prove a direct threat to a practicing dentist in the absence of any evidence showing that the magnitude of risk to a dentist is comparable to the risk to other health-care workers in other settings. Nor is such an equivalency obvious; health-care workers in, say, emergency rooms may be exposed to much larger needles and more copious quantities of blood than are common in routine dental practice.

Generalities about health-care workers aside, Dr. Bragdon does not cite a single confirmed instance of HIV transmission to a dentist. He does, of course, point to seven instances of "possible

9 Then, too, the stakes are different. The only foreseeable loss from what may be an overabundance of caution on the FDA's part is some small quantity of donated blood. Surrendering to stereotypes and unfounded fears when dealing with disabled persons, however, will subvert Congress' intent in enacting the ADA.

transmissions" of HIV to dental workers, but mere possibilities are too speculative to satisfy a litigant's burden of production at the summary judgment stage. See Smith, 76 F.3d at 428 (noting that unsupported speculation must be disregarded at summary judgment); Medina-Munoz, 896 F.2d at 8 (similar).

3. Dr. Bragdon brandishes a CDC report telling of the transmission of HIV from a Florida dentist to his patients. But neither the CDC report nor any other proffered evidence establishes transmission of HIV from a patient to a dental worker. The difference is meaningful. Dentists have the advantage of equipping and staffing their offices and dictating the precautionary procedures that will be utilized during patient encounters. In contrast, patients have no way of assuring that any particular risk-reduction measures, much less the universal precautions recommended by the CDC, are introduced. Given that dentists are in a superior position to patients in terms of protecting against infection, a single report of dentist-to-patient infection cannot reasonably be taken to suggest a direct threat to dentists from their patients' infections.

4. The high-speed drills that dentists use when filling cavities may also generate aerosol mists of water, blood, and bloody saliva. Using this datum as a springboard, Dr. Bragdon jumps to the conclusion that a study by researchers at the Stanford Medical School, raising concerns about transmission of HIV when dentists perform aerosol generating procedures, is sufficient to defeat summary judgment. See Gregory K. Johnson and William S. Robinson, Human Immunodeficiency Virus-1 (HIV-1) in the Vapors of Surgical Power Instruments, 33 Journal of Medical Virology 47 (1991). By its own characterization, however, the Johnson-Robinson paper is too conjectural to raise a genuine issue of material fact

as to whether filling Ms. Abbott's cavity would constitute a direct threat to Dr. Bragdon's health. The paper notes that it "do[es] not quantitate the risk of HIV transmission . . . by such aerosols," and that "the large body of epidemiologic data on prevalence of HIV infections . . . would suggest that transmission by aerosols is not common." Id. at 49.

5. Dr. Bragdon points out that the CDC did not state that it was medically unwise to take additional precautions with persons known to be HIV-positive. This observation, while true, gains him little ground. Such silence on the part of the CDC is at best equivocal; it does nothing to prove that there is any risk to a dentist in treating HIV-positive patients. Because the inference that Dr. Bragdon seeks to draw from the CDC's silence is wholly conjectural, it cannot figure in the summary judgment calculus.[10] See Smith, 76 F.3d at 428.

6. Dr. Bragdon adverts to the Association's report that the risk to health-care workers is greater than the risk to patients. At the same time, he notes, federal courts have found a significant risk of HIV transmission from health-care workers to patients. See, e.g., Bradley v. University of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922, 924 (5th Cir. 1993) (per curiam), cert. denied, 510 U.S. 1119 (1994); Doe v. Washington Univ., 780 F. Supp. 628, 633 (E.D. Mo. 1991). Dr. Bragdon seeks to lace these findings together to support a conclusion that the risk to him from treating Ms. Abbott is also significant. The tie does not bind; this combination produces far too much of a generalization to have any force in the much narrower contours of this case.

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10 In all events, it is implicit in the 1993 CDC guidelines that no risk-reduction steps beyond the universal precautions are necessary to ensure the safety of dentists providing routine dental care to HIV-positive individuals. See supra p. 24.

Moreover, the federal cases involving transmission of HIV from health-care workers to patients are inapposite not only because of the asymmetry of control of risk-reduction measures between health-care workers and patients, see supra, but also because the cited cases spring from a context in which any risk at all to patients is deemed unacceptable. See Washington Univ., 780 F. Supp. at 633 ("It is the stated goal of the medical profession to heal, and its secondary axiom, if healing is not possible, is not to harm.") Therefore, these cases do not support a reasoned inference that rendering routine care to a dental patient infected with HIV constitutes a direct threat to the dentist's health.

7. Dr. Bragdon states that although he did his best to comply with the universal precautions, he still sustained sharp injuries on a regular basis. We believe that this kind of anecdotal evidence by a dentist who is not an expert on infectious disease is inadequate to block summary judgment. See Medina-Munoz, 896 F.2d at 8 (noting that summary judgment may be granted when opposing evidence is not significantly probative). Although courts need not defer slavishly to the judgments of public health officials, see supra Part IV(B), we believe it would be inconsistent with Arline were courts to credit lay testimony on matters of public health. See Arline, 480 U.S. at 287-88 (emphasizing the need to protect the handicapped from unfounded fears).

8. Dr. Bragdon cites a study reporting that compliance with the universal precautions would reduce needlestick exposures by only 62%. See Edward S. Wong et al., Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?, 265 Journal of the American Medical Association 1123, 1126 (1991). This statistic says nothing about the initial baseline degree of danger of treatment in

the absence of the universal precautions and thus is impuissant to prove that a dentist using the CDC's precautions is directly threatened by treating an HIV-positive patient.

At this point, we have reviewed all the proof relevant to direct threat that Dr. Bragdon claims was available to him in September of 1994. Each piece of evidence is too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact. This ends our item-by-item explication of the record.

We next consider whether these eight proffers, in cumulation, possess greater probative force. This can occur when items of evidence, each insufficient in itself to prove a particular point, complement each other, like interlocking pieces of a jigsaw puzzle, in such a way that they together demonstrate some material fact. Thus, had Dr. Bragdon cited separate sources of evidence demonstrating (a) the likelihood of dental needlestick and (b) the likelihood of a dentist contracting HIV from a needlestick, these items together possibly would have been adequate to defeat summary judgment on the direct threat defense. Or, had he proffered several items of evidence that each showed a small risk to the health or safety of others, the aggregate effect of these items might have sufficed to prove a significant risk and thus to thwart summary judgment.

Despite the fact that Dr. Bragdon did not explicitly make a "cumulative proof" argument, we have spontaneously reviewed the record with this thought in mind. Having done so, we are satisfied that the evidentiary proffers canvassed above, insufficient in themselves, are likewise insufficient in combination to call into legitimate question the lower court's entry of summary judgment. In making this evaluation, we emphasize that, under the ADA, a service provider like

Dr. Bragdon is not entitled to demand absolute safety; he can rely upon the direct threat defense only in response to significant risks. Here, Dr. Bragdon has failed to present meaningfully probative evidence that treating Ms. Abbott would have posed a medically significant risk to his health or safety.

V. CONCLUSION

For the reasons indicated, we rule that Ms. Abbott's HIV-positive status is a physical impairment which substantially interferes with her major life activity of reproduction, and that she is therefore disabled within the meaning of the ADA. Inasmuch as Dr. Bragdon has failed to produce sufficient evidence to establish a triable issue on his direct threat defense, the entry of summary judgment in Ms. Abbott's favor must stand.

Under ordinary circumstances, we would go no further. Here, however, we believe that more should be said. It is sometimes convenient to think of cases as involving conduct that may be categorized in terms of polar extremes: reasonable or unreasonable, praiseworthy or blameworthy, good or evil. But, given the complexities of the society in which we live, many decisions resist such facile classification into black-or-white dichotomies. Such cases are better characterized in varying shades of gray.

This is such an instance. The litigants' positions are understandable in human terms and impartial observers can empathize with both parties. Still, on the facts of record, the defendant's refusal to render routine dental care to an HIV-positive patient offends a duly enacted federal statute and thus cannot be tolerated by a court of law.

Although we do what we must, we are not blind to the difficulty of the choices that the ADA compels health-care professionals such as Dr. Bragdon to make.

We also recognize that cases of this kind are necessarily fact-sensitive; had the patient required more invasive treatment or had the dentist proffered stronger evidence of a direct threat, the result may well have differed. In the same vein, presented with other facts and circumstances in a future case, perhaps reflecting dramatic improvements in medical science that substantially reduce the likelihood of transmitting HIV through reproduction, we might well reach a different conclusion than the one that we reach today. Such an ebb and flow is to be expected, because this is the very nature of the inquiry that the ADA mandates. We therefore caution future courts not to read our words more broadly than the context admits; our decision today eschews a blanket rule and instead demands case-by-case inquiry into a service provider's responsibilities to treat HIV-positive patients.

Affirmed.

ORDER AND MEMORANDUM OF DECISION

BRODY, District Judge.

Plaintiff Sidney Abbott, an individual with Human Immunodeficiency Virus ("HIV") filed this action against Defendant Randon Bragdon, a dentist with a practice in Bangor, Maine. Plaintiff's Amended Complaint alleges violations of title III of the Americans with Disabilities Act ("ADA" or "title III") and the Maine Human Rights Act ("MHRA") based on Defendant's refusal of treatment in his office. Defendant offered alternative treatment to Plaintiff in a hospital setting. Plaintiff seeks injunctive and declaratory relief under the ADA and MHRA, and civil penal damages under the MHRA. Both the United States ("Government") and the Maine Human Rights Commission ("MHRC") have intervened as Plaintiffs, and all Parties have moved for Summary Judgment. For the following reasons, the Court grants Summary Judgment for Plaintiff, and denies Summary Judgment for Defendant.

Background

The undisputed facts are as follows. Plaintiff Sidney Abbott has been infected with HIV for the past nine years. HIV is a retrovirus which causes Acquired Immune Deficiency Syndrome ("AIDS"). People exposed to HIV may contract the virus, and if so, will develop HIV antibodies and become HIV positive. HIV positive status does not equate with manifest illness. Individuals may carry HIV for several years without manifesting the collection of symptoms known as AIDS. During that period, the HIV carrier remains asymptomatic, meaning apparently healthy and generally able to participate in

day to day life. Even in the asymptomatic phase, however, the HIV carrier's blood remains infected with a multiplying virus that creates abnormalities in that person's blood and lymphatic systems. To date, Plaintiff remains asymptomatic.

Defendant, Randon Bragdon, a dentist licensed to practice in the state of Maine, has operated a dental practice in Bangor since 1978. In September of 1994, Plaintiff arrived at Defendant's office for apre-scheduled dental appointment. On her Patient Registration and Health Record form, Plaintiff indicated that she had HIV. Defendant examined Plaintiff and diagnosed a cavity. Defendant informed Plaintiff that pursuant to his infectious disease policy, he would not fill her cavity in his office, but would be glad to treat her in a hospital setting. Defendant then told Plaintiff that he would charge her the standard fee for filling a cavity as well as what the hospital charged for use of its facilities.

With respect to the ADA, the Parties dispute (1) whether Plaintiff's asymptomatic HIV constitutes a disability under the statute, and *(2)* whether treatment of Plaintiff in Defendant's office poses a direct threat to the health and safety of others such that Defendant may lawfully refuse such treatment. With respect to the MHRA, the Parties dispute whether Defendant's office constitutes a place of public accommodation. Finally, Defendant challenges the ADA on various constitutional grounds.

Discussion

A. Summary Judgment

Courts properly grant summary judgment when the moving. party demonstrates the absence of a genuine issue of material fact, and that it is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party may rely on deposition testimony, answers to interrogatories, admissions on file and affidavits to meet its burden. Id. In addition the moving party may satisfy its burden by demonstrating an absence of evidence to support an essential element of a claim for which the nonmoving party bears the burden of proof. *Celotex Corp. v. Catrett,* 477 U.S. 317, 325, 106 S.Ct. 2548, 2554, 91 L.Ed.2d 265 (1986). To defeat summary judgment, the nonmoving party need only present evidence from which a jury might return a verdict in its favor. *Anderson v. Liberty Lobby,* 477 U.S. 242, 257, 106 S.Ct. 2505, 2514, 91 L.Ed.2d 202 (1986). The nonmoving party, however, may not rest on mere allegations or denials, but must employaffidavits, admissions, deposition testimony and answers to interrogatories to set forth specific facts establishing a genuine issue for trial. Fed.R.Civ.P. 56(e).

B. ADA

Under title III, a place of public accommodation may not discriminate ate against an individual on the basis of a disability in the full and equal enjoyment of services. 42 U.S.C. § 12182(a). Places of public accommodation, however, may deny full and equal enjoyment of services to an individual who poses a direct threat to the health or safety of others. 42 U.S.C. § 12182(b)(3). To find a violation of title III, therefore, the

Court must determine that (1) Defendant's office constitutes a place of public accommodation, (2) Plaintiff has a disability for purposes of the ADA, and (3) treatment of Plaintiff in Defendant's office does not pose a direct threat to the health or safety of others. Defendant does not dispute that his office constitutes a place of public accommodation under the ADA.[1] The Court also concludes that Plaintiff is disabled as a matter of law, and that treatment of Plaintiff in Defendant's office poses no direct threat to the health and safety of others.

1.Plaintiff is Disabled as a Matter of Law

Title III of the ADA prohibits a place of public accommodation from discriminating in equal use of services on the basis of disability. Under the ADA, disability means "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such an impairment." 42 U.S.C. § 12102(2). Defendant contends that asymptomatic HIV does not constitute a *per se*

[1] **Based on the statute and interpretive guidelines, Defendant's office constitutes a place of public accommodation. The Department of Justice interpretive guidelines for the ADA define a place of public accommodation as including the professional office of a health care provider whose operations affect interstate commerce. 28 C.F.R. § 36.104. While not binding, such regulations carry significant persuasive weight. See *Chamberlin v. 101 Realty, Inc., 915* F.2d 777, 781 (1st Cir.1990).**

disability, and that Plaintiff has failed to offer evidence upon which to conclude that her asymptomatic HIV substantially limits any major life activity.

The ADA classifies neither HIV, nor any other disease or condition, as a *per se* disability.[2] Instead, application of the statute to a given individual depends on whether that individual has a physical or mental impairment, and whether that impairment substantially limits a major life activity of that individual. 42 U.S.C. § 12102(A). The Court is persuaded that asymptomatic HIV constitutes a physical impairment for the purposes of the ADA. The interpretive guidelinesspecifically include HIV, whether symptomatic or asymptomatic, among the types of diseases that constitute disabilities. 28 C.F.R. § 36.104. The vast weight of the authority also supports the

2 The Court departs from the analysis employed by the two district courts that have considered the factual issue presented in this case. See *D.B.* v. *Bloom,* 896 F.Supp. 166, 170 (D.N.J.1995): *United States of America v. Morvant,* 898 F.Supp. 1157. 1161 (E.D.La.1995). In both of those cases, the courts assumed that since the interpre2.

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proposition that HIV constitutes a physical impairment for the purposes of the ADA.[3] *See Gates v. Rowland,* 39 F.3d 1439, 1446 (9th Cir.1994); *Doe v. Garrett,* 903 F.2d 1455, 1459 (11th Cir.1990), *cert. denied,* 499 U.S. 904, 111 S.Ct. 1102.113 L.Ed.2d 213 (1991); *EEOC v. Chemtech International Corp.,* 1995 WL 608355 at *1 (S.D.Tex.1995); *Austin v. Pennsylvania Department* of *Corrections,* 876 F.Supp. 1437,1465 (E.D.Pa.1995); *Robinson* v. *Henry* Ford *Health Systems, 892* F.Supp. 176, 180 (E.D.Mich.1994); *Howe v. Hull,* 873 F.Supp. 72, 78 (N.D.Ohio 1994); *Doe v. Kohn Nast & Graf, P.C.,* 862 F.Supp. 1310, 1318-20 (E.D.Pa.1994); *T.E.P.* v. *Leavitt, 840* F.Supp. 110, 111 (D.Utah 1993); *Doe v. District of Columbia,* 796 F.Supp. 559, 568 (D.D.C. 1992); *Glanz v. Vernick,* 756 F.Supp. 632, *635* (D.Mass.1991).

Less clear is whether Plaintiff's asymptomatic HIV substantially limits one or more of her major life activities. See 42 U.S.C. § 12102(2)(A). The Court concludes that it does. Plaintiff identifies reproduction as the sole major life activity that her asymptomatic HIV substantially limits. She asserts that the risk of transmitting HIV to a potential child, as well as possible harm to her own immune system has deterred her from having children.[4] The Court, therefore, must inquire (1)

3 The interpretive guidelines state that the ADA shall not be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973. 28 C.F.R. § 36.103. Thus, cases construing similar language in the Rehabilitation Act impact interpretation of the ADA.

4 Intervenor Plaintiff MHRC further asserts

whether reproduction constitutes a major life activity,and, if so, (2)whether Plaintiff's HIV substantially limits hat major life activity. 42 U.S.C. § 12102(2)(A). An examination of both of these inquiries leads the Court to conclude that Plaintiff's asymptomatic HIV substantially limits her major life activity of reproduction.

As a matter of common sense, the outcome of the first inquiry seems obvious. Reproduction, one of the most fundamental of human activities, must constitute a major life activity. From the perspective of the ADA, however, that issue becomes somewhat murky. The interpretive guidelines define "major life activities" as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 23 C.F.R. § 36.104. At least one court has determined that reproduction does

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that asymptomatic HIV substantially limits other major life activities such as the victim's sex life. A close reading of the statutory language, however. reveals the need for an individual determination of substantial limitation. See 42 U.S.C. § 12102(2)(A) (disability requires substantial limitation of major life activity of "such individual"). Accordingly, while the MHRC may be generally correct that asymptomatic HIV can substantially limit a victim's sex life. Plaintiff has offered no evidence on that issue, leaving the Court unable to analyze it in a Summary Judgment context.

not constitute a major life activity for the purposes of the ADA, reasoning that one does not engage in reproduction with the same frequency as walking, seeing, speaking, breathing, learning and working. *Zatarain v. WDSU Television, Inc.,* 881 F.Supp. 240, 243 (E.D.La. 1995).

The Court, however, concurs with the majority of courts who have concluded that reproduction does constitute a major life activity. *See Erickson v. Northeastern Illinois University,* 911 F.Supp. 316 at 321, (N.D.Ill. 1995); *Pacourek v. Inland Steel Co.,* 858 F.Supp. 1393. 1404-05 (N.D.Ill.1994); *Kahn Nast* & Graf, *P.C.,* 862 F.Supp. at 1320-21; *District of Columbia, 796* F.Supp. at 568; Cain v. *Hyatt, 734* F.Supp. 671, 679 (E.D.Pa. 1990). Rather than limit major life activities, the interpretive guidelines define major life activities as functions such *as* caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. 28 C.F.R. § 36.104 (emphasis added). Use of the words "such as" indicatesan illustrative, not exclusive, list of major life activities. *Kahn, Nast & Graf,* 862 F.Supp. at 1320. Moreover, as the Eastern District of Pennsylvania points out, Congress chose to use the broad term "major life activities" rather than a more limited term, such as "major work activities." *Id.* In other settings, the interests in conceiving and raising one's own children have been recognized as essential and basic civil liberties. *Cain,* 734 F.Supp. at 679 (citing *Stanley* v. *Illinois,* 405 U.S. 645, 651, 92 S.Ct. 1208, 1212, 31 L.Ed.2d 551 (1972).

Reducing reproduction to the specific act of conception ignores the processes that occur continually in both male and female reproductive systems in order to achieve conception. *Erickson,* 911 F.Supp. at 321. Limitation of reproduction to conception also ignores the

process of raising and caring for offspring upon which successful reproduction depends. The reasoning of courts that have already considered the issue, as well as the broad language of both the statute and the interpretive guidelines persuade this Court that reproduction constitutes a major life activity for the purposes of the ADA.

Finally, based on the undisputed evidence, the Court concludes that Plaintiff's asymptomatic HIV substantially limits her major life activity of reproduction.[5] The Parties have not presented evidence that Plaintiff's asymptomatic HIV posēs a direct barrier to Plaintiff's ability to reproduce, in the sense, for example, that it has rendered her infertile. The statutory language, however, does not require such a stringent inquiry. By requiring an individual's physical or mental impairment to substantially limit a major life activity, the statute does not contemplate a complete inability of thatindividual to engage in a particular major life activity. See 42 U.S.C. § 12102(2)(A) (emphasis added).

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5 In order to constitute a disability, an individual must have a physical or mental impairment that substantially limits a major life activity *"of such individual."* 42 U.S.C. § 12101(2)(A) (emphasis added). Thus. the Court's inquiry is not whether such impairment substantially limits the major life activity of reproduction generally. but whether in this case, Plaintiff's asymptomatic HIV substantially limits her major life activity of reproduction. *See id.*

Child birth poses a risk of physical harm to an asymptomatic HIV mother. *See Thomas v. Atascadero Unified School District,* 662 F.Supp. 376, 379 (C.D.Cal.1986) (childbirth dangerous to asymptomatic HIV patient and others). In her deposition Plaintiff testified that fear of harm to her immune system contributed to her decision not to have children once she tested positive for HIV (PL's Dep. at 79.) In addition, an HIV positive mother runs the risk of infecting her child, during pregnancy, through child birth or, if she chooses to do so, through breast feeding. In her deposition, Plaintiff also indicated that fear of infecting her child contributed to her decision not to have children. (PL's Dep. at 79.) Finally. as previously indicated, reproduction extends beyond the act of conception and the period of gestation, to the process of caring for and raising a child. In her deposition, Plaintiff cited fear that her child would lose its mother as another reason for not having children. (Pl.'s Dep. at 79.) Defendant does not dispute any of Plaintiff's asserted reasons for not having children, and those reasons all stem from her HIV positive status. The Court concludes that Plaintiff has established that her asymptomatic HIV has substantially limited her major life activity of reproduction.[6]

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6 Defendant offers statistics demonstrating a 25% risk of transmission of HIV from mother to child and argues that such a low risk cannot possibly translate into a disability under the ADA.

Defendant. however, misconstrues the inquiry. The Court has determined that the HIV virus constitutes a physical impairment under the ADA. The Court has also concluded that reproduction constitutes a major life activity.

The Court concludes that Plaintiff is disabled as a matter of law under the ADA.

2.Treatment of Plaintiff in Defendant's Dental Office Poses no Significant Risk to the Health and Safety of others

The ADA does not require a covered entity to extend its public accommodations to any individual who poses a direct threat to the health or safety of others. 42 U.S.C. § 12182(b)(3). Direct threat means "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services." *Id.* The interpretive guidelines further define direct threat as a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures. 28 C.F.R. § 36.208(b). In determining whether an individual poses a direct threat, the guidelines contemplate that "a public accommodation must make an individualized assessment, based on reasonable medical judgment that relies on current medical knowledge ... to ascertain: the nature, duration. and severity of the risk; the probability that the potential injury will actually occur: and whether reasonable modifications of policies. practices. or procedures will mitigate the risk." 28 C.F.R. § 36.208(c); *see also School*

Thus, the Court's inquiry is not whether a low risk of transmission from mother to child constitutes a disability under the ADA, but whether asymptomatic HIV in this case substantially limits Plaintiff's major life activity of reproduction.

Board of Nassau County v. *Arline,* 430 U.S. 273. 287-88. 107 S.Ct. 1123, 1131, 94 L.Ed 2d 307 (1987) (employing similar factors in Rehabilitation Act, employment discrimination context).

Defendant asserts that performance in his office of invasive dental procedures, such as filling a cavity, on HIV patients poses a significant risk to the health and safety of others that cannot be eliminated. Plaintiff contends that implementation of Centers for Disease Control (CDC) recommended precautionary measures eliminates any significant risk in-office treatment may pose, and, therefore, that Defendant's infectious disease policy as applied to her and similarly situated HIV patients constitutes discrimination on the basis of a disability for purposes of the ADA.[7]

a. Weight of the Evidence

Pursuant to Rule 56, litigants may not base their Motions or opposition to Motions for Summary Judgment

[7] The CDC has issued guidelines to reduce the risk of transmission of infectious diseases in a report entitled Recommended Infection-Control Practices for Dentistry, published in 1993. The CDC provides recommendations concerning every aspect of dental practice, including vaccinations for dental workers, protective attire and barrier techniques. hand care. use of sharp instruments and needles, sterilization of instruments, disinfection of the dental unit and environmental surfaces, use and care of hand pieces and other dental devices, single use disposable instruments, etc.

on mere allegations or denials of the adverse party's pleading. Fed. R.Civ.P. 56(e). Instead, Summary Judgment requires affidavits, depositions or answers to interrogatories that set forth specific facts as would be admissible in evidence. Id. In the context of the direct threat inquiry, the interpretive guidelines provide specific guidance to courts analyzing the risk to a public accommodation under title III. C.F.R. § 36.208(c). The interpretive guidelines codify, for ADA purposes, the analysis employed by the Supreme Court in a Rehabilitation Act context. *See Arline,* 480 U.S. at 288, 107 S.Ct. at 1131. The Supreme Court, in *School Board of Nassau County v. Arline,* emphasized that courts engaging in such an analysis "normally should defer to the reasonable medical judgments of public health officials." *Id.*

The Parties' arguments focus on how HIV can be transmitted and the probability of transmission in the dental health context, two of the four analytical prongs established by the interpretive guidelines. *See* 28 C.F.R. 36.208(c). Defendant asserts that performing invasive dental procedures on Plaintiff creates a significant risk of transmission of HIV through contact with Plaintiff's blood.

Defendant points out that filling a cavity involves injecting the mouth with anesthetic and drilling the decayed tooth. Use of a needle creates a risk of transmission through percutaneous needle stick injury, while drilling creates a risk of transmission through spattering and misting blood and bloody saliva. While Defendant asserts that both of these results create an obvious risk of transmission of HIV, Defendant fails

tooffer the Court Summary Judgment quality evidence to support that assertion.[8] Fed.R.Civ.P. 56. Instead, Defendant argues that quantification of the risk may be impossible, since documentation of the transmission of HIV from infected patient to dentist in many cases may not occur, and, therefore, such transmission may be occurring with alarming frequency. Again, Defendant fails to offer evidence to support that assertion.

Defendant buttresses his argument with tangential statistics. Defendant points out that three to four percent of the individuals who carry HIV have not identified any of the risk factors for becoming infected. By contrast, Defendant asserts, six percent of all health care workers who have contracted HIV exhibit no risk factors. Finally, Defendant points out that in 42 documented cases, health care workers have suffered occupational transmission of HIV Defendant concludes that although no documented case of a dentist suffering occupational transmission has occurred, that will likely change. In lieu of the reasonable medical judgment of a public health official. Defendant

[8] Although the Supreme Court directs district courts to defer to the reasonable judgment of public health officials. *Arline* faded to reach the issue of whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied. 480 U.S. at 288 n. 18.107 S.Ct. at 1131 n. 18. Defendant relied on the expert testimony of Sanford Kuvin, M.D. With respect to transmission through aerosol mist. Dr. Kuvin testified that although no one knows whether such transmission is possible, no evidence currently supports aerosol spray as a mode of transmission of HIV.

essentially asks the Court to infer a significant risk from a combination of his conjecture as to potential transmission and statistics which at best may place health care workers at a higher risk of contracting HIV.[9] The Court cannot grant Summary Judgment on the basis of allegation or speculation. *See* Fed.R.Civ.P. 56. Instead, the Court must evaluate the risk based on the current state of medical knowledge, and defer to the reasonable medical judgments of public health officials. 28 C.F.R. 36.208; *Arline,* 480 U.S. at 288, 107 S.Ct. at 1131. Defendant has failed to meet his Summary Judgment burden.

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9 Defendant asserts that the Federal Drug Administration ("FDA") believes the risk of occupational transmission to dentists is significant, based on the FDA's recommendation that any person who has been exposed to the blood of a patient in the previous year should not be permitted to donate blood. The FDA recommendations pertain to prevention of HIV transmission by blood and other blood products. Nowhere does the FDA express a concern regarding the occupational risk of transmission to dentists. The FDA simply lists among several other criteria for donor unsuitability "persons who have had contact with blood and body fluids through percutaneous inoculation (such as injury or accidental needlestick) (Def.'s Mem.Opp n.Summ. J., Ex. 4a at 4-5.) Based on that statement alone. the Court is not willing to infer that the FDA has determined that dentists suffer a significant risk of occupational transmission.

Plaintiff, by contrast, offers the reasonable medical judgment of a public health official, CDC, to refute Defendant's allegations that treatment of her in his office poses a direct threat. Specifically, Plaintiff presented testimony from Wayne Marianos, D.D.S., M.P.H., who serves as Captain in the United States Public Health Service at the Centers for Disease Control ("CDC"), and who currently serves as the Director of the Division of Oral Health. Dr. Marianos participated in the development of the CDC recommended precautions for dentists to prevent the transmission of infectious diseases. He testified both as to the risk of transmission of HIV in a dental setting, as well as to the CDC recommended practices designed to minimize that risk. Dr. Marianos testified that when implemented, the CDC recommendations reduce the already low risk of disease transmission in the dental environment, from either patient to dental health care worker, dental health care worker to patient, or patient to patient. Dr. Marianos further testified that routine dental treatment to persons with HIV or AIDS requires no additional procedures beyond the CDC recommendations.[10] In other words,

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10 Plaintiff also offers the opinion of the American Dental Association, which concurs with Dr. Marianos that routine adherence to the recommended procedures results in little risk of transmission, and stresses that a dentist should not refuse to treat a patient whose condition is within the dentist's current realm of competence solely because the patient carries HIV.

Plaintiff has provided evidence, of Summary Judgment quality, of a reasonable medical judgment of a public health official, based on current medical knowledge, that treating HIV positive patients such as Plaintiff in a dental office does not pose a direct threat to the health and safety of others.[11]

b. *Weight of the Authority*

Both Parties assert that the weight of judicial authority supports their position. Defendant points to a line of case law in which courts have held that the suspension or termination of HIV infected health care workers does not constitute discrimination under title III. *See Doe* v. University *of Maryland Medical System Corporation,* 50 F.3d 1261, 1267 (4th Cir.1995); *Bradley v. University of Texas M.D. Anderson Cancer Center. 3* F.3d 922.925 (5th Cir.1993), *cert. denied.* - U.S. - 114 S.Ct. 1071, 127 *L.Ed.2d 389 (1994): Leckelt v. Board of Commissioners of Hospital District No.1.* 909 F.2d 820, 830 (5th Cir.1990); *Mauro v. Borgess Medical Center,* 886 F.Supp. 1349, 1354

11 With respect to the other two analytical prongs, the duration and severity of the risk, the evidence demonstrates that the risk is lifelong, in that no cure for HIV exists, and, severe, in that the potential harm to third parties, here Defendant, is illness and death. *See Arline,* 4S0 U.S. at 288 107 S.Ct. at 1131 (explaining test). In this case, however, neither the duration nor severity outweigh the evidence as to how the disease is transmitted and the slight probability of transmission. See *Morvant.* 898 F.Supp. at 1166.

(W.D.Mich.1995); *Scoles v. Mercy Health Corporation,* 887 F.Supp. 765, 772 (E.D.Pa.1994); *Doe v. Washington University,* 780 F.Supp. 628, *634-35* (E.D.Mo.1991). Defendant argues that the health care worker cases further support his assertion that Plaintiff poses a direct threat to the health and safety of others. The Court concludes, however, that the key distinction in those cases-HIV infected health care workers as opposed to patients--renders them inapposite to this case.

The HIV health care worker cases that mention the judgment of a public health authority rely on CDC recommendations for minimizing transmission of infectious diseases from health care workers topatients, rather than from patients to dentists. *See University of Maryland,* 50 F.3d at 1263; *Bradley,* 3 F.3d at 924; *Leckelt,* 909 F.2d at 828 and n. 17; *Washington University,* 780 F.Supp. at 633. In *Doe v. University of Maryland System Corporation,* for example, the CDC recommendations indicated that hospitals could bar HIV infected health care workers from performing those procedures the hospital had identified as exposure prone. 50 F.3d at 1263, 1266*; see also Bradley, 3* F.3d at 924 (same CDC recommendations); *Leckelt,* 909 F.2d at 828 (prior version of same guidelines). As indicated, deference to the relevant CDC guidelines in this case, combined with the testimony of one of the authors of those guidelines, logically compels this Court to a different conclusion.

A closer examination of some of the health care worker cases reveals that HIV infected health care workers posed a direct threat in part because of the nature of the relationship between health care provider and patient. *See University* Of *Maryland,* 50 F.3d at 1266; *Mauro, 886* F.Supp. at 1353; *Washington University,* 780

F.Supp. at 633-34. The court in *Doe v. Washington University,* for example, viewed the risk of transmission from a dental student to patient in the context of the stated goal of the medical profession "to heal, and ... if healing is not possible, . . . not to harm." 780 F.Supp. at 633. According to that court, to permit even an occasional death to occur because of a failure to scrupulously guard the safety of patients would appear to be morally unacceptable. 780 F.Supp. at 633-34; *see also University of Maryland,* 50 F.3d at 1266 (defendant made a considered decision to err on side of caution and acted solely with patients' best interests in mind); *Mauro,* 886 F.Supp. at 1353 (exposing patient to direct risk of acquiring a fatal disease is fundamentally inconsistent with mission of patient care).

The health care provider-patient relationship, however, is not symmetrical. Defendant in this case does not occupy the same vulnerable position as patients in the case of an HIV infected dentist, because Defendant, and not Plaintiff. controls the level of risk. The reasonable medical judgment of the CDC indicates that a dentistprotects him or herself by diligently implementing the CDC recommended precautions. Compliance with the CDC recommended precautions, however, is up to the dentist. A patient has no control over the less diligent health care provider whose failure to comply with CDC guidelines significantly increases the risk of patient infection. *See, e.g., Leckelt,* 909 F.2d at 829-30 (evidence suggested that plaintiff nurse failed to comply with CDC recommendations). In *Leckelt v. Board of Commissioners of Hospital District No.1;* the plaintiff, an HIV infected nurse, asserted that as long as he followed the CDC guidelines, he posed little or no risk of transmitting HIV to his patients. 909 F.2d at 829. Evidence of his failure to

consistently comply with the CDC guidelines, as well as hospital policies based on those guidelines, undermined his argument. *Id.* at 829-30. The Fifth Circuit pointed out that by his conduct, the plaintiff prevented the defendant hospital from deciding what measures, if any, were necessary to protect the health of the plaintiff, other employees and patients. *Id.* at 830. Implicit in that finding is the Fifth Circuit's concern that no amount of reasonable medical judgment as to risk reduction can protect a patient from an incautious health care provider. *See id.* In this case, by contrast, Defendant exercises complete control over the reduction of his risk, and bears the consequences of a lapse in his diligence. That critical difference fatally undermines Defendant's efforts to apply the health care workers cases to the direct threat analysis in this case.

Indeed, the federal courts that have examined the same or factual scenarios similar to those present in this case have concluded that the risk of transmission from patient to dentist does not rise to the level of a direct threat to the health or safety of others and that refusals to treat HIV positive patients in the dental office constitutes unlawful discrimination under the ADA. *See D.B. v. Bloom,* 896 F.Supp. 166, 170 n. 6 (D.N.J.1995) (similar facts established prima facie case under ADA and no medically justified reason existed for defendant's refusal to treat HIV infected plaintiff); *United States of America v. Morvant,* 898 F.Supp. 1157, 1166-67 (E.D.La.1995). In *Morvant,* a dentist referred HIV infected patients to another dentist rather than treat them in his office.898 F.Supp at 1159. In analyzing whether the HIV infected patients posed a direct threat to the dentist, the court pointed to "a plethora of expert testimony presented by the government" that the CDC's recommendations, if

implemented, would significantly mitigate any risk. *Id.* at 1166. As in *Morvant,* this Court has made a similar finding based on the reasonable medical judgment of a public health official.[12] *See Arline,* 480 U.S. at 288, 107 S.Ct. at 1131.

Defendant has provided neither Summary Judgment quality evidence, nor judicial authority that can lead to the conclusion that treatment of Plaintiff in his office constitutes a direct threat to the health and safety of others. Plaintiff has refuted Defendant's speculative evidence with the reasonable medical judgment of a public health official, in this case, the CDC. Defendant has failed to demonstrate that CDC's judgment is medically unsupportable. *See id.* at 286 n. 15. 107 S.Ct. at 1130 n. 15. This Court, therefore, must defer to the CDC, and concludes that if Defendant implements the CDC recommended precautions, treatment of Plaintiff in his

12 The court in *Morvant* viewed the CDC recommended precautions as modifications that would eliminate the direct threat. 898 F.Supp. at 1166. This Court disagrees with that analysis. CDC recommends that dentists implement the precautions in virtually every procedure. They are universal. As such, CDC contemplates that the precautions will become part of the normal practice routine in dentistry. The Court, therefore, views the precautions as part of the practice of dentistry, and concludes that in light of modern dental methods, treatment of Plaintiff does not pose a direct threat to the health and safety of Defendant, his staff, or his patients.

office poses no direct threat to the health or safety of others.[13]

C. MHRA

The Parties have also moved for Summary

13 The implementing guidelines indicate that a public accommodation must make an individualized determination of whether the extension of services to that individual would pose a direct threat to the health or safety of others. 28 C.F.R. Sec. 36.208. Nothing in the Court's conclusion should be interpreted as preventing Defendant, upon an individualized assessment, from determining in a given case that treatment of a patient with a disability in his office would pose a direct threat to the health and safety of others. By the same token, while this opinion applies specifically to Plaintiff, the implications of the reasonable medical judgment of the CDC are that treatment of HIV positive individuals in a private dental office generally does not pose a direct threat to the health and safety of others. In other words, an individualized assessment as to whether treatment of a particular patient poses a direct threat to the health and safety of others must consider the four pronged analysis offered by the interpretive guidelines, and must defer to the reasonable medical judgment of a public health official where such judgment is available, *See id., Arline,* 480 U.S. at 288,107 S.Ct. at 1131.

Judgment on Plaintiff's MHRA claims. The Maine Supreme Court has indicated that analogous federal law informs the interpretation of the MHRA. *Bowen v. Department of Human Services,* 606 A.2d 1051, 1053 (Me.1992); *Plourde v. Scott Paper Co.*. 552 A.2d *1257,* 1261-62 (Me.1989). This is particularly true in a question of first impression. *Bowen,* 606 A.2d at 1053. Defendant seeks a separate MHRA finding only with respect to whether his office constitutes a place of public accommodation. The Court concludes that Defendant's office constitutes a place of public accommodation under the MHRA, and, therefore, applies the findings with respect to discrimination under the ADA to Plaintiff's MHRA claim.

Similar to the ADA, the MHRA prohibits public accommodations from discriminating on the basis of disability. 5 M.R.S.A. § 4592. The MHRA defines a place of public accommodation as "any establishment that in fact caters to, or offers its goods, facilities or services to, or solicits or accepts patronage from, the general public, and includes but is not limited to:"... clinics, hospitals..." 5 M.R.S.A. § 4553(8). Defendant urges construction of the MHRA in accordance with the principles of *ejusdem generis, arguing* that private dental offices are not similar enough to the enumerated public accommodations to be included under the MHRA. *See Buker v. Town of Sweden,* 644 A.2d 1042, 1044 (Me.1994) (citing *Penobscot Nation* v. *Stilphen,* 461 Aid 478, 489 (Me.1983)) (under *ejusdem generis, a* general term followed by a list of illustrations is assumed to embrace only concepts similar to illustrations). The Court disagrees.

The prefatory language prior to the enumerated list of public accommodations is extremely broad and

includes any establishment that offers its facilities or services to the general public. 5 M.R.S.A. § 4553(8). By itself, that language includes a commercial dental office. The prefatory language also indicates that the definition of public accommodations *includes* but is *not limited* to the list of illustrations. 5 M.R.S.A. § 4553(8) (emphasis added). In light both of the breadth of the language and its stated non-exclusivity, it strains neither logic nor statute to include private dental offices within the definition of public accommodations.

As indicated, the Maine Supreme Court directs courts interpreting the MHRA to look to analogous federal law for guidance, particularly in questions of first impression. *Bowen,* 606 Aid at 1053. The Court has not found a single Maine case answering the inquiry of whether a private dental office constitutes a public accommodation under the MHRA. None of the Parties, however, disagree that Defendant's office constitutes a public accommodation tinder the ADA.

Accordingly, the Court concludes that Defendant's office constitutes a place of public accommodation under the MHRA. Based on the Court's findings with respect to Plaintiff's ADA claim, the Court concludes that Defendant's conduct also violates the MHRA.

D. Constitutional Issues

Defendant challenges the constitutionality of the ADA as applied to him on three grounds: (1) Congress lacks the authority under the Commerce Clause to regulate his dental practice; (2) the ADA violates Defendant's due process right to freedom from unjustified intrusions on his personal security; and (3) the

ADA violates Defendant's due process right to freedom of contract. The Court concludes that the ADA passes constitutional muster under all three of Defendant's challenges.

1. Commerce Clause

Defendant, citing the Supreme Court's recent decision in *United States* v. *Lopez*, - U.S. - 115 S.Ct. 1624, 131 L.Ed.2d 626 (1995), argues that the activity of filling a cavity does not substantially affect interstate commerce, and that the practice of dental medicine is an area of law reserved to the states, and thus beyond the scope of Congress' Commerce Clause authority.

Congress' power to regulate commerce derives from Article I, section 8 of the United States Constitution. The Supreme Court has construed the Commerce Clause as a broad grant of regulatory authority to Congress. *Hodel* v. *Virginia Surface Mining & Reclamation Association, Inc.*, 452 U.S. *264*, 276, 101 S.Ct. 2352, 2360, 69 L.Ed.2d 1 (1981). Congress' commerce power is "complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the Constitution." *Id.* (Citing *Gibbons v. Ogden*, 9 Wheat. 1, 196, 6 L.Ed. 23 (1824)).

The Supreme Court has identified three types of activity that constitute commerce under the Commerce

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Article I, section 8 reads in relevant part, "The Congress shall have the power ... [t]o regulate Commerce . . . among the several states."

Clause. Lopez, - U.S. at ---, 115 S.Ct. at 1629-30. These include (1) the use of the channels of interstate commerce. (2) the instrumentalities of interstate commerce or persons or things in interstate commerce, or (3) those activities having a substantial relationship to interstate commerce. *Id.* In the event that the target activity of a regulation constitutes commerce, that regulation must then survive rational basis scrutiny, meaning that the regulation must be rationally related to a legitimate constitutional end, and the means chosen by Congress must be reasonably tailored to reach that end. *Heart of Atlanta Motel, Inc. v. United States;* 379 U.S. 241, 262, 85S.Ct. 348, 360, 13 L.Ed.2d 258 (1964); *Hodel,* 452 U.S. at 276, 101 S.Ct. at 2360.

The Court notes that the preliminary question of whether an activity has a substantial enough effect on commerce to fall within the boundaries of congressional commerce authority is left to the courts. *Katzenbach* v. *McClung*, 379 U.S. 294, 303, 85 S.Ct. 377, 383, 13 L.Ed.2d 290 (1964); *Lopez*, - U.S. at--, - n. 2, 115 S.Ct. at 1629, 1629 n. 2. Defendant argues that because the activity at issue--dental medicine---curs purely intrastate, this Court must find that it substantially affects commerce in order to find it within Congress' regulatory authority under the Commerce Clause. *See United States v. Robertson*, - U.S. --, --, 115 S.Ct. 1732, 1733, 131 L.Ed.2d 714 (1995) (affecting commerce test designed to define extent of congressional authority over purely intrastate activity). The Court finds that Defendant's intrastate dental practice has a substantial enough impact on interstate commerce to fall within Congress' regulatory purview under the Commerce Clause.

Under the Commerce Clause, Congress may

regulate one entity's purely intrastate activity, even if that activity has a minimal affect on interstate commerce, provided that entity belongs to a class whose aggregate activity substantially affects commerce among the states or with foreign nations. *Hodel,* 452 U.S. at 277.101 S.Ct. at 2360 (citing *Fry v. United States,* 421 U.S. 542,547, 95 S.Ct. 1792, 1795 *44* L.Ed.2d 363 (1975)); *Katzenbach,* 379 U.S. at 300-01, 85 S.Ct. at 381-82; *see also Wickard v. Filburn,* 317 U.S. 111.127-28,63 S.Ct. 82, 90-91, 87 L.Ed. 122 (1942). Thus, even if Defendant's purchase of supplies and equipment from out of state. receipt of payments from out of state insurers and credit card companies, and attendance of classes and conferences out of state by themselves do not substantially affect interstate commerce, the Court is satisfied that those commercial activities, taken together with the activities of other dentists similarly situated, have an effect on interstate commerce substantial enough to fall within the reach of congressional authority under the Commerce Clause. *See Katzenbach,* 379 U.S. at 300-01. 85 S.Ct. at 381-382; *Wickard,* 317 U.S. at *127-28, 63* S.Ct. at 89-90.

Defendant argues that none of the interstate transactions in which he engages bear on the determination of whether Congress can constitutionally regulate him.[15] Instead, Defendant asserts, the Court must

[15] Defendant also asserts that the ADA regulation of the practice of dentistry is not commerce because dentistry is an area of law reserved for the states. Notably, Defendant provides no authority for his assertion. Moreover, this argument ignores the proper inquiry inCommerce Clause cases. Under the Commerce Clause, 380 (D. Me. 1995)

focus solely on the narrow activity the ADA is attempting to prohibit, the filling of a cavity in a hospital rather than a dental office. Defendant contends that filling a cavity in a hospital rather than his office can have no greater effect on interstate commerce than possession of a gun in a "school zone," which the Supreme Court recently examined *in Lopez,-- U.S.* at--, 115 S.Ct. at 1626 (description of Gun Free School Zones Act of 1990 at issue).

In striking down the Gun Free School Zones Act, the *Lopez* Court focused on the nature of that statute, concluding that by its terms the Gun Free School Zones Act neither regulated commercial nor economic activity, nor bore any nexus to such activity. - U.S. at ---, 115 S.Ct. at 1630-31. Instead, the Supreme Court reiterated a familiar theme running through modern Commerce Clause jurisprudence: "[w]here economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained." *Id.* at -, at 1630. The Supreme Court emphasized that the statute at issue in *Lopez* had nothing to do with commerce. - U.S. at - 115 S.Ct. at 1630-31.

By contrast, title III of the ADA seeks to regulate purely economic activity--in this case, the provision of dental services. Defendant is not asserting that he does not accept fees for performing dental services. Indeed, the

> Congress may regulate any economic activity that substantially affects interstate commerce. Lopez, - U.S. at------ 115 S.Ct. at 1630. As a constitutional matter, therefore, Congress may regulate Defendant's dental practice, an economic activity, provided dental medicine substantially affects interstate commerce. Id.

very activity upon which he seeks the Court to focus--the way in which he fills cavities--constitutes one of the core economic activities of any dental office. Defendant cannot credibly argue that regulation of an economic enterprise that trades in interstate commerce, even one centered on filling cavities, lacks the commercial element or nexus to Commercial activity the Supreme Court found lacking in the Gun Free School Zones Act. *See Lopez,* —, U.S. at ——— 115 S.Ct. at 1630-31.

Having determined that title III of the ADA appropriately regulates Defendant's dental practice, the Court must also determine whether title III survives rational basis scrutiny, meaning that title III must be rationally related to a legitimate constitutional end, and that the means chosen by Congress must be reasonably tailored to reach that end. *Hodel,* 452 U.S. at 276, 101 S.Ct. at 2360; *Heart of Atlanta Motel, 379 U.S.* at 262, 85 S.Ct. at 360. Defendant does not contest title III on rational basis grounds, and the Court concurs in the judgment of the *Morvant* Court that title III meets this minimal scrutiny. *See* 898 F.Supp. at 1167 (up-holding constitutionality of ADA through application of rational basis scrutiny).

2. Freedom from Unjustified Intrusions on Personal Security

Defendant next contends that by forcing him to treat HIV positive patients in his office, the ADA contravenes the fundamental right to freedom from unjustified intrusions on his personal security which derives from the Fifth and Fourteenth Amendments to

the Constitution. While the Court acknowledges that the Due Process Clauses of the Fifth and Fourteenth Amendments protect such a fundamental right or liberty interest, the Court is not persuaded that Defendant establishes such an interest in this case. *See Youngberg* v. *Romeo,* 457 U.S. 307, 315-16, 102 S.Ct. 2452, 2457-58, 73 L.Ed.2d 28 (1982) (personal security interest recognized in context of confinement by state); *Ingraham* v. *Wright,* 430 U.S. 651, 673, 97 S.Ct. 1401, 1413, 51 L.Ed.2d 711 (1977) (personal security interest recognized in context of corporal punishment of child in public school). None of the cases illuminating the fundamental right to freedom from unjustified intrusions on personal security rest on factual situations even remotely similar to this case.[16] The Court declines to expand this fundamental right to this factual situation.[17]

16 One of the Cases upon which Defendant bases his personal security argument, *Russell* v. *Steck,* 851 F.Supp. 859,863 (N.D.Ohio 1994), has been expressly rejected by the *Sixth* Circuit. *Foy v. City of Berea,* 58 F.3d 227, 231 (6th Cir.1995).

17 The ADA does not require Defendant to treat anyone who poses a direct threat to the health and safety of others. 42 U.S.C. § 12182(b)(3).

The Court has concluded that treatment of Plaintiff in Defendant's dental office poses no significant risk to the health and safety of others. Thus, even if Defendant correctly identified an application of the fundamental right to freedom from unjustified intrusions on his personal security, that right would not

3. Freedom of Contract

Defendant asserts that the ADA also violates his fundamental right to freedom of contract, also deriving from the Fifth and Fourteenth Amendments to the Constitution, by forcing him to accept patients against his will. Defendant relies on *Meyer* v. *Nebraska,* a 1923 case in which the Supreme Court, in fleshing out a due process privacy right, mentioned liberty of contract among other interests protected by due process. 262 U.S. 390.
399, 43 *S.Ct. 625.* 626, 67 L.Ed. 1042 (1923). The *Meyer* Court cited *Lochner v. New York,* 198 U.S. 45, 25 S.Ct. 539, 49 L.Ed. 937 (1905), among other cases, *as* support for the fundamental right to freedom of contract. *Id.* The *Lochner* case and its progeny employed freedom of contract to strike down social legislation regulating aspects of the work place. *See, e.g., Lochner,* 198 U.S. at 52, 25 S.Ct. at541 (maximum hours statute violated freedom of contract); *Coppage v. Kansas,* 236 U.S. 1, 6, 35 S.Ct. 240, 240, 59 L.Ed. 441 (1915) (statute prohibiting employers from requiring employees *to* sign agreements not to join Unions violated freedom of contract); *Adkins v. Children's Hospital,* 261 U.S. 525, 539, 43 S.Ct. 394, 395, 67 L.Ed. 785 (1923) (minimum wage for women statute violated freedom of contract). The Supreme Court, however, has dramatically curtailed the due process right to freedom of contract which Defendant seeks to invoke against the ADA.[18]

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prevent Congress from applying the ADA to him in this context.

18 In *Planned Parenthood v. Casey.* the Supreme Court discussed the demise of the *Lochner* line

In *West Coast Hotel Co. v. Parrish,* the Supreme Court expressly overruled Adkins, and commenced a reigning in of the due process right to freedom of contract. *See* 300 U.S. 379.391, 400, 57 S.Ct. 578, 581, 586, 81 L.Ed 703 (1937). The Parrish Court announced that "[l]iberty under the Constitution is ... necessarily subject to the restraints of due process, and regulation which is reasonable in relation to its subject and is adopted in the interests of the community is due process." 300 U.S. at 391, 57 S.Ct. at 581. The rigor with which courts scrutinize economic legislation since *Parrish* has continued to decline. *See Williamson* v. *Lee Optical Co. of Oklahoma Inc., 348* U.S. 483, 488, 75 S.Ct. 461.464, 99 L.Ed. 563 (1955) ("it is enough that there is an evil at hand for correction and that it might be thought that the particular legislative measure was a rational way to correct it"). In *Williamson v. Lee Optical,* for example, the Court was satisfied that it could contemplate any reason for the legislative action at issue, setting an extremely deferential standard of review. 348 U.S. at 487, 75 S.Ct. at 464. In light of *Parrish* and its progeny, which Defendant has declined to discuss, the Court determines that due processfreedom of contract fails to provide grounds for declaring the ADA unconstitutional. [19]

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of cases, noting that it serves as one of only two examples in history in which the Court, despite the principles of *stare decisis,* reversed a line of cases. See 505 U.S. 833. 360. 112 S.Ct. 2791, 2812, 120 L.Ed.2d 674 (1992).

19 The Court acknowledges that the due *process* cases upon which it relies examined state statutes under the Due Process Clause of the

Conclusion

The Court concludes that Defendant's refusal to treat Plaintiff in his dental office constitutes a violation of title III of the ADA and the MHRA. In so concluding, however, the Court in no way suggests that Defendant's motivation is suspect. The position taken by Defendant is not an unreasonable one. The Court is sensitive to Defendant's concerns about the possibility of the transmission of HIV from a patient to him, his staff and other patients, particularly in light of how much science has yet to learn about HIV. The arguments raised by Defendant to support his position are not without merit.

This case ultimately boils down to statutory analysis and evidence. Although Defendant raises some frightening possibilities about the transmission of HIV and the ramifications of those possibilities on dentists, Plaintiff offers the reasonable medical judgment of a public health official that the risk to Defendant does not rise to the level of a direct threat. While that reasonable

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Fourteenth Amendment. A similarly deferential standard applies with respect to due process challenges to federal statutes. See e.g., *Duke Power Co. v. Carolina Environmental Study Group*, 438 U.S. 59, 83.98 S.Ct. 2620, 2635, 57 L.Ed.2d 595 (1978) (upholding federal regulation in absence of evidence Congress acted irrationally or arbitrarily).

medical judgment may change in thefuture as the state of knowledge on HIV transmission changes, the Court must make a present determination based on current medical knowledge. 28 C.F.R. Sec. 36.208(c); *Arline,* 480 U.S. at 288, 107 S.Ct. at 1131. The Court has made its determination, and now concludes that Defendant has violated title III of the ADA and the MHRA.

Disposition -

For the above reasons. the Court:

(1) GRANTS Plaintiff's Motion for Summary Judgment;

(2) GRANTS the Government's Motion for Summary Judgment on the constitutional issues;

(3) GRANTS the MHRC's Motion for Summary Judgment

(4) DENIES Defendant's Motion for Summary Judgment.

SO ORDERED.

Enforcement

The Court *has* determined that Defendant's conduct violated title III of the ADA, specifically, 42 U.S.C. § 12182(b)(2)(A)(i), and the MHRA, specifically 5 M.R.S.A. § 4592(1). Under both statutes, the Court retains broad authority to grant equitable relief for violations. *See* 42 U.S.C. § 12188(b)(2); 5 M.R.S.A. § 4613. Plaintiff seeks injunctive and declaratory relief under the ADA and

MHRA, as well as civil penal damages under the MHRA. Plaintiff also seeks attorney fees and costs.

Based on the factual record assembled for these Motions, it is *ORDERED:*

(1) Defendant is enjoined from refusing to provide treatment in his office to individuals infected with HIV solely on the basis off their HIV positive status, without making an individualized assessment, based on current medical knowledge and the reasonable medical judgment of public health officials, that in-office treatment of any such individual poses a direct threat to the health and safety of others;

(2) the Parties must submit memoranda to this Court relating to any further injunctive relief requested by Plaintiff, civil penal damages, if any, under the MHRA, and attorney fees and costs. Those memoranda shall be submitted on a schedule to be agreed upon by the Parties and approved by the Court.

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 96-1643

SIDNEY ABBOTT, ET AL.,
Plaintiffs-Appellees,

v.

RANDON BRAGDON, D.M.D.,
Defendant-Appellant.

BEFORE

*

ALDRICH, SENIOR CIRCUIT JUDGE,
SELYA, BOUDIN, STAHL AND LYNCH,
CIRCUIT JUDGES.

ORDER OF COURT

Entered: April 2[illegible], 1997

The panel of judges that rendered the decision in this case having voted to deny the petition for rehearing and the suggestion for the holding of a rehearing en banc having been carefully considered by the judges of the Court in regular active service and a majority of said judges not having voted to order that the appeal be heard or reheard by the Court en banc.
It is ordered that the petition for rehearing and the

suggestion for rehearing en banc be denied.

By the Court:

WILLIAM H. NG, CLERK
Chief Deputy Clerk

*
Chief Judge Torruella, dissenting.
[cc: Messrs. McCarthy, Sfikas, Klein, Carnes, Bagenstos, Greenwald and Ms. Levin]

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

SIDNEY ABBOTT,
Plaintiff

Cvil Action No. 94-0273-B

vs.

RANDON BRAGDON, D.M.D.,
Defendant

AFFIDAVIT OF RANDON BRAGDON, D.M.D.

The affiant, Randon Bragdon, D.M.D., being duly sworn deposes and says:

1. My name is Randon Bragdon. I am of legal age and under no legal disability. I have personal knowledge of the facts stated in this affidavit and know them to be true and correct.

2. I hold a Bachelor of Arts in Physics from the University of Maine.

3. After I received by degree in physics, I worked for two years as the training engineer for General Electric. Later, I worked for two years as an electro-optical engineer for Block Engineering, and then started by own electrical contracting business in Maine called Bragdon Electric.

4. In 1975, I began dental school at Tufts

Dental School. I graduated from Tufts in 1978 and received my D.M.D. (Doctor of Dental Medicine). In 1978, I received a license in Maine to practice dentistry. Since then, that license has never been suspended nor revoked.

5. I began my private practice of dental medicine in Bangor in 1978. Since then, I have seen over 8,000 patients and have performed thousands of invasive dental procedures, including filling thousands of cavities.

6. When Ms. Abbott visited my office on September 16, 1994, I found that she had a cavity near her gum line on a back, lower, left-side tooth. In technical terms, this would be called a buccal lesion at the cervix of tooth number 19.

7. When I fill a cavity such as Ms. Abbott's, I start by giving one or more injections of local anesthetic into the tissues surrounding the tooth. This process involves grasping the area to be injected with my thumb and stabilizing the patient's head and jaw with my other fingers as I insert the needle beside my thumb, withdraw the needle, and often inject again to ensure complete nerve blockage. During this process, if the patient starts to bite down, which is common, or flinches, I can, and have, stuck myself with the needle just before, between, or after injections, even if I was not careless. Such accidents, though relatively infrequent, are inevitable.

8. To remove the decay from a cavity such as Ms. Abbott's, I and other dentists start by using a high speed bur (patients often call it a drill) that turns at 400,000 revolutions per minute. In contrast, a typical high speed electric drill for a home workshop operates at

approximately 1200 revolutions per minute.

9. The drilling process usually generates aspattering of blood or bloody saliva, especially when the cavity is next to the gum line.

10. To keep the tooth from overheating when it is being drilled at such a high speed, my (and other dentists') handpiece emits a continuous cooling spray of water and air. As this spray hits the tooth, gum, and rotating bur, an aerosol mist is generated consisting of tiny droplets of water, blood, and bloody saliva. These droplets remain suspended in the air and drift up into the dentist's face, or they eventually land and remain on other surfaces three to six feet away.

11. Attached to this affidavit is a copy of page 73 of a book called Practical Infection Control in Dentistry (Lea & Febiger 1991) written by James Cottone, Geza Terezhalmy, and John Molinari. John Molinari is one of Ms. Abbott's experts in this case.

12. The narrative indicates that the splashing of saliva illustrated in figures 1-6 is from a single, class-II operative procedure on a mandibular second molar. In layman's terms, this is filling a single cavity on a back, lower tooth, such as Ms. Abbott's. In my experience, having performed hundreds of such procedures, the figures accurately depict the type of splashing of saliva in such procedures. Much of the saliva in such procedures also contains blood in it, and as can be seen, the bloody saliva spreads over many surfaces.

DATED: September 18, 1995 /s/Randon Bragdon, D.M.D.

STATE OF MAINE
PENOBSCOT, ss

September 18, 1995

Personally appeared the above-named Randon Bragdon, who first being duly sworn, made oath that the foregoing affidavit which he has signed and to which he subscribed is based on his own personal knowledge and that the facts set forth therein are true.

Before me,
/s/

Notary Public

VICKY J. NEALE NOTARY PUBLIC
My Commission Expires 0ctober 23, 2000

Fig. 4–2

73a

Fig. 4–3

Fig. 4–4

74a

Fig. 4–5

Fig. 4–6

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

SIDNEY ABBOTT,
Plaintiff **Civil Action No. 94-0273-B**

vs.

RANDON BRAGDON, D.M.D.,
Defendant

SECOND AFFIDAVIT OF RANDON BRAGDON, D.M.D.

I, Randon Bragdon, D.M.D., being duly sworn, state as follows:

1. In his supplemental affidavit, paragraph 11, Ms. Abbott's expert witness John A. Molinari, Ph.D., made the following statement:

> **According to Dr. Bragdon's Statement of Facts, his practice is to place his fingers in the patient's mouth next to the needle while he injects the anesthetic. The currently recommended procedure involves removing one's hand from the injection site, retracting the cheek with a mirror, and injecting anesthetic with the other hand. This method virtually eliminates any risk that a dentist will be stuck with a needle during the injection of a local anesthetic.**

2. The recommendation made in this statement most likely comes from a person who has no experience giving intraoral injections. It does not surprise me that this novel but dangerous technique is not described in the

book Practical Infection Control In Dentistry Dr.Molinari co-authored with James A. Cottone, D.M.D., M.S. and Geza T. Terezhalmy, D.D.S., M.A.

3. Dr. Molinari also failed to alert the audience to this novel technique during his speech at the American Conference on the Dental Management of HIV Disease held in Chicago June 16-18, 1995. The title of his speech was "Infections of Risk to Healthcare Providers" and did include discussion of percutaneous injuries including needlesticks. Furthermore, another plaintiff's expert witness Dr. Donald Marianos gave a speech at the same meeting entitled "Update on Transmission Risks for Providers, Patients Needlestick, Splash Injury Implications, and Protocol for Healthcare Providers." Dr. Marianos also failed to alert the audience to this new technique for giving injections. Had he done so, I believe the audience of experienced professionals would have been incredulous.

4. Another plaintiff's expert witness, Dr. Deborah Greenspan, in the book AIDS and the Mouth she co-authored with Dr. John S. Greenspan, Dr. Morten Schiodt, and Dr. Jens J. Pindborg(deceased) makes no mention of such a technique. In fact, Dr. Greenspan states on pages 180 and 181: "In 1987, an ADA survey reported that general dentists gave an average of 177 local anesthetic injections per month and that the rate for needlestick injuries was 1.5 per 100 injections."

5. Also attached is the program brochure for the three day conference entitled "Frontline Healthcare Workers: National Conference on Prevention of Sharps Injuries and Bloodborne Exposures" held in Atlanta on August 14-16, 1995. This conference did not discuss Dr.

Molinari's novel solution for prevention of needlesticks either.

6. It is well-known that the vast majority of needlesticks which occur during dental injections are the result of unexpected movements of either the patient or someone else in or entering the operatory. Most people do not realize that the reason that most needlesticks occur in the mouth is that it is the lesser of two evils. When control of a needle is lost either in or approaching the mouth by anunexpected movement, the patient must be protected from potentially serious injury. Often, the only practical way of preventing injury to the patient is for the dentist to position his or her hand and fingers so as to steady the head and jaw and to block an errant needle. Better the dentist be stuck than the patient seriously injured.

7. Dr. Molinari may not realize it, but the technique he advocates is based upon a cavalier attitude toward needle injuries to patients. Without exaggeration, using his proposed technique, I would have punctured at least two eyes, to say nothing of needle punctures of the face, lips, out through the cheek, into the throat, etc. Every injection is an intense moment in a dental procedure. Any patient may move unexpectedly or have an unexpected complication during any injection. I have had a well-behaved boy drive an explorer into the bone of my left index finger which was holding a mirror in a retraction capacity when he was startled by someone entering the operatory. (An explorer Is the "shepherd's crook" used to examine teeth.) An explorer is much more user friendly than a needle. It was medically preferable for my finger tohave been punctured than for the explorer to have gone out through his cheek.

8. Most persons can readily visualize unexpected patient movements during dental injections such as turning the head, movements of the lower jaw and tongue, flailing and grasping with the arms and hands, twisting and turning the body and kicking. But there are other important causes of unexpected movements (e.g. the patient may faint, have a epinephrine reaction, have a panic attack, lift a leg up and bring it down abruptly causing the head to reactively jerk up from the chair several inches, or someone (usually a parent or sibling) may lean on the foot of the dental chair moving it).

9. I have attached two color copies of pages from the book Handbook of Dental Local Anesthesia by Hans Evers, D.D.S. and Glenn Haegerstam, M.D. This book was published in 1981 before universal precautions. Therefore, the dentists and assistants are not wearing masks, gloves or protective eyewear. However, the pictures are illustrative and the text is still informative.

10. The technique advocated by Dr. Molinari is ill conceived and inherently dangerous to patients. The reason, perhaps, that Dr. Molinari does not appreciate the inherent dangers of his proposed method of dental intraoral injections is that, to my knowledge, he has never given dental injections. He is a Ph.D , not a dentist or an M.D.

11. I incorporate as though fully set forth herein the statements contained in paragraphs 1-4 of my previous affidavit dated September 18, 1995.

Subscribed and sworn to by me on this 18th day of

October, 1995.

/s/ Randon Bragdon
D.M.D.

STATE OF MAINE
PENOBSCOT, ss.
Oct. 18 , 1995

Personally appeared the above-named Randon Bragdon, D.M.D., who, first being duly sworn, made oath that the foregoing affidavit which he has signed and to which he subscribes is based on his own personal knowledge and that the facts set forth therein are true with the exception of those facts which are based upon his information and belief and that, as to those facts, he believes the information to be true.

Before me,

/s/
Name: Susan Tuholski
Notary Public My Commission Expires
24 June 2001

Attorney-at-Law

INTERROGATORY NUMBER 4

Describe in detail what occurred when you appeared at Dr. Bragdon's office as is alleged in paragraph 7 of your complaint.

RESPONSE TO INTERROGATORY NUMBER 4

OBJECTION: Ms. Abbott objects to Interrogatory Number 4 because the word "detail" is vague and unclear. Without waiving this objection, Ms. Abbott answers Interrogatory Number 4 as follows:

When I arrived at Dr. Bragdon's office, a receptionist asked me to fill out a medical questionnaire form. The form included questions about whether I was HIV-positive or had AIDS. I filled out the questionnaire and indicated that I was HIV-positive. I returned the form to Dr. Bragdon's receptionist. I then entered Dr. Bragdon's treatment room. Dr. Bragdon examined my mouth by probing with instruments in the general area where I indicated I had a toothache--the lower left corner of my mouth. Dr. Bragdon told me that I had a cavity that needed to be filled. Dr. Bragdon also asked me if I had any medical conditions. I told him that I was HIV-positive. He also asked if I had any symptoms. I answered "no." He then indicated that he did not treat anyone with an infectious disease including HIV or AIDS in his office. He said that he would treat me in a hospital. I asked Dr. Bragdon if I would be required to pay for the cost of the hospital. He said that I would be required to pay for the cost of the hospital. I told Dr. Bragdon that I would think about it and get back to him.

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(D) Qualitative Assessment of HIV Risk

The CDC estimates that there are between 1 million and 1.5 million HIV infected persons in the U.S. (Ex. 6-356). *As* of September 30, 1990 occupational information was available for 122,159 of the AIDS cases reported to CDC. Of these, 5,815 or 4.8% were identified as healthcare workers (Ex. L6-666) (note:Exhibit L6-666 is an updated version of Exhibit 6-378). This proportion is similar to the proportion of the labor force employed in the healthcare field.

Most healthcare workers with AIDS also belong to some other group which places them at high risk for HIV infection (e.g. homosexual men, intravenous drug users, etc.). There is, however, a statistically significantly larger proportion of healthcare workers with no known risk factors (6%), than the proportion of other AIDS cases (i.e. individuals with AIDS not in the healthcare field) with no known risk factors (3%). As of September 30, 1990, there were 337 reported cases of healthcare workers with AIDS with no known risk factors. These cases are being studied further. CDC reports that 89 could not be assigned to a risk group after follow-up. 65 had either died or refused to be interviewed, and 203 were still under investigation (Ex. L6-666).

Because the prevalence of HIV- infection among healthcare and other workers with occupational exposure to blood or other potentially infectious material is unknown, it is not possible to estimate an "observed" infection rate. Therefore, it is not possible to quantify the risk as was done for occupational exposure to HBV. Certain deductions, however, can be made. It is known that the virus is present only in blood or certain body fluids and that exposure to these fluids from an HIV-infected person puts one at risk for HIV-infection.

Therefore, workers who have occupational exposure to blood or certain body fluids are at risk.

No case of infection due to casual contact with these fluids has been documented. Rather, infection can occur only if infectious fluids enter the body either through a percutaneous or mucosal route, although exposure by either of these routes does not mean that infection will occur. In several prospective studies of healthcare workers with HIV exposures, seroconversions have been observed. Although the rate of infection is low, it is not insignificant.

. . .

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Dental Facilities: Dentists, dental hygienists, dental assistants and dental assistants and dental laboratory technicians are continually exposed to blood and bloody saliva during almost all dental procedures. Because saliva in dental procedures is so likely to contain blood, the CDC recommends personal protective equipment to practitioners for all dental procedures, (Ex. 6-316). The record contains many references to occupational hepatitis B infections in dental health professionals. (Exs. 6-68;6-441)

Ms. Karen Boulton, a dental hygienist who testified at the public hearings, gave examples of preventive dental hygiene services, including scaling and polishing of the teeth, periodontal root planing and subgingival curettage. She estimated that "almost 100 percent of [her] patients in private practive exhibit some extent of bleeding during routine treatment." (Tr. 1/16/90, pp.563-565)

A number of commenters who considered this issue agreed that these supported a standard for dental operations (Exs. 11-162; 11-177;11-327)

The position of the American Dental Association (ADA) regarding the scope of the standard and the major provisions was given by Dr. Enid Neidle in her testimony at the public hearing on the proposed rule. She stated, in part:

The purpose of OSHA in protecting, through this proposed rule, the health care worker is clear, unequivocal, and laudable. The American Dental Association shares that purpose. Over the past 15 years, the Association has invested substantial resources in the development of educational materials to prevent the transmission of infection in the dental office. (Dr. Enid Neidle, ADA. Ex. 58)

However, the ADA stated its belief that OSHA overstated the risks to dental healthcare workers in the preamble to the proposed standard.

* * *

In any case, we will address the points made by the ADA to support their contention that OSHA has overestimated the occupational risk faced by dentists. First, it would be more complete to say that the Klein study, cited above in the quote from the ADA, found five (5) HIV infected dentists, not one (Ex. 6-366). Four of these individuals were found to have other risk factors leaving one occupational HIV infection in a group of 1,132 dentists. A finding of 1 occupational HIV infections in a group of 1,132 dentists, or 2 occupational HIV infections in a group of 4,973 for that matter, is not "extremely low" or "minimal" or "insignificant" as the ADA has argued. On the contrary, this finding is compatible with a finding of a 1 in 1,000 risk of a fatal illness as the result of an occupational exposure. In the

"Benzene Decision," the Supreme Court clearly defined this as a significant risk. (See Section VI: Significance of Risk) This does not take into consideration the additional occupational risk caused by HBV. The ADA's contention that the HIV risk in dentists is lower than that of the general population is confusing and is not supported by the data the ADA cited in their posthearing comments. They use the figure "2 HIV infected dentists per 4,973" and as we have noted above, the Klein study alone found 5 HIV infected dentists (5 per 1,132). There is no information in the record to indicated how many other HIV positive dentists with other risk factors were found in the other group that make up the total 4,973 tested individuals. Second, in the past it has been relatively uncommon for dental hygienists, dental assistants and dental laboratory technicians to be tested for HIV following occupational exposure. Since an HIV infection may be silent for many years before AIDS develops, it is highly unlikely that untested individuals would know whether or not they were infected with HIV.

* * *

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta Georgia 30333
OCT 30 1995

The Honorable Daniel P. Moynihan
United States Senate
Washington, D.C. 20510-3201

Dear Senator Moynihan:

I am responding to your letter on behalf of Dr. Paul Dworkis regarding his concerns about the efficacy of barrier precautions, such as gloves and masks, to prevent the transmission of bloodborne organisms during the provision of dental care.

The Centers for Disease Control and Prevention (CDC) published Recommended Infection Control Practices for Dentistry in 1986 and updated them in 1993. CDC infection control recommendations are intended to address a broad spectrum of dental procedures and are developed and updated with advice from outside consultants, including experts in infection control and public health. While many infection control recommendations are based on extensive epidemiologic data, others are based on established principles of infection control.

Gloves and masks (also known as personal protective equipment) are worn to provide a protective barrier and to prevent gross contamination of skin and mucous membranes of health care workers when touching blood or saliva contaminated with blood. The efficacy of these precautions (combined with other measures, including handwashing after removing gloves) to reduce blood contact with skin and mucous membranes has been well documented in the scientific literature.

Enclosed are references that support the use of personal protective equipment during medical and dental procedures. In addition, enclosed are the two latest articles that establish the efficacy of such practices.

I hope this information is helpful.

Sincerely,

/s/
David Satcher, M.D., Ph.D.
Director

Enclosures

(JAMA. 1991;265:1123-1128)

Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?
A Prospective Study of Physicians on a Medical Service

Edward S. Wong, MD; Jennifer L. Stotka, MD; Vernon M. Chinchilli, PhD; Denise S. Williams, MT; C. Geri Stuart, MT; Sheldon M. Markowitz, MD

Using a daily questionnaire, we prospectively studied 277 physicians from two hospital medical services for incidents of exposure to blood and body fluids and barrier use before and after the implementation of universal precautions. We found that implementation significantly increased the frequency of barrier use during exposure incidents from 54% before implementation to 73% after implementation of universal precautions. Implementation led to a decrease in the number of exposure incidents that resulted in direct contact with blood and body fluids (actual exposures), from 5.07 to 2.66 exposures per physician per patient care month, and to an increase in averted exposures in which direct contact was prevented by the use of barrier devices, from 3.41 exposures per patient care month before implementation to 5.90 exposures per patient care month after implementation. Implementation affected neither the types of body fluid or procedures involved nor the overall rate of exposure incidents (8.5 per patient care month) but, through an increase in barrier use, it *did* prevent direct contact with blood and body fluids and thus converted what would have been an actual exposure into an averted one. We conclude that universal precautions were effective in reducing the risk of occupational exposures among physicians on a medical service.

* * *

COMMENT

In August 1987, the CDC published recommendations for the universal use of protective barrier devices to protect health care workers ~ fromblood-borne pathogens.[12] However, despite the theoretical benefits of UPs and strong endorsements for their adoption, little evidence exists to show that UPs will protect health care workers as intended. Our study is one of the few to demonstrate that UPs can reduce the number of occupational exposures. We demonstrated by prospective surveillance that implementation of UPs was associated with a significant reduction in the number of actual exposures sustained by physicians from 5.07 exposures per PCM in the preimplementation period to 2.66 exposures per PCM in the postimplementation period. We attribute this benefit largely to the effect of implementation on barrier use, since the decrease in actual exposures was inversely proportional to the increase in the frequency of barrier use and to the increase in the number of averted exposures (Table 3). Although we cannot be certain that implementation was the only factor, we are unaware of any other factor or change in patient care routine occurring during the study period that may have contributed to this reduction. In particular, we considered the number of patients admitted to study wards to be an important and potentially confounding variable since admissions directly affect the number of diagnostic procedures and patient care manipulations performed and, therefore, exposure risk. However, the monthly census was similar in both the preimplementation and postimplementation periods, and

regression analysis found it not to be a contributing factor (Table 4).

To the extent that implementation reduced the number of actual exposures, it should also reduce the risk of occupationally acquired blood-borne infections. Variables that affect acquisition include the cumulative number of exposures, the transmission rate per exposure, and the prevalence of disease. [21] For HIV infection, needlestick injuries carry the highest risk of transmission at 0.4% per episode of exposure. Since the rate of needlestick injuries fell from 0.39 to 0.15 episodes per *PCM* (a reduction of 62%), we estimate that the implementation of UPs should reduce the risk of occupational HIV infection by the same rate (62%) since the other variables (transmission rate and prevalence) remain unchanged. For HBV, implementation of UPs should have an even greater impact since in most localities the prevalence of HBV is higher than HIV, the efficacy of transmission per exposure episode is greater (6% to 32% per exposure episode vs 0.4% for HIV), and exposures other than needlestick injuries (mucous membrane or nonintact skin exposures) have been known to transmit infection.[22-24]

* * *

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Food and Drug Administration
Bethesda MD 20892

Date:	April 23, 1992
From:	Director, Center for Biologics Evaluation and Research
Subject:	Revised Recommendations for the Prevention of Human Immunodeficiency Virus (HIV) Transmission by Blood and Blood Products
To:	All Registered blood Establishments

INTRODUCTION

On September 25, 1991 the Food and Drug Administration (FDA) licensed the first enzyme immunoassay (EIA) for the simultanecus detection of antibodies to human immunodeficiency virus type 1 (HIV-1) and type 2 (HIV-2) in human serum and plasma. This test, manufactured by Genetic Systems Corporation, is based on whole viarl lysate antigens. Another combination EIA, based on recombinant antigens, and manufactured by Abbott Laboratories, received a license on Febraury 14, 1992. These tests are indicated for detection of antibodies to HIV-1 and/or HIV-2 in human serum or plasma. the tests may be used for donor screening and as an aid in the diagnosis of potential infection with HIV-1 and/or HIV-2.

The availability of licensed screening tests for combined detection of anitbodies to HIV-1 and HIV-2 provides blood centers with the capability of performing routine HIV-2 screening without the need to implement a second test in addition to the curremtly required test for antibodies to HIV-1. Based on this possibility, the issue of whether to recommend donor screeening for HIV-2 was discussed at a meeting of the Blood Products Advisory Committee on SEptember 27, 1991.

At the time of the meeting, only 31 cases of HIV-2 infection in the U.S.A. had been reported to the Centers for Disease Control, despite extensive surveillance studies. (One additional case has been reported since then.) These data indicated that HIV-2 infections presently represent only a minimal risk to the safety of the blood supply. Nevertheless, from a public health persepective, use of combination tests offers an opportunity to further protect the safety of blood recipients against HIV-2 infection without requiring an increased number of tests in blood centers. Donor screening for anitibodies to HIV-2 would also reduce the need for coninuted surveillance studies which are expensive, difficult to sustain, and might nevertheless fail to prevent the earliest cases of HIV-2 transmission by blood products.

For these reasons, and with the concurrence of the Blood Products Advisory Committee, the FDA recommends that all establishments collecting whole blood, blood components, Source Plasma or Source Leukocytes implement a licensed test for detection of antibodies to HIV-2 by June 1, 1992. For this purpose the Agency finds acceptable either the use of a licensed combination test for detection of antibodies to HIV-1 and HIV-2 or the use of

two separate tests licensed for detection of these antibodies.

To implement HIV-2 testing, modifications are necessary to the current recommendations for the prevention of HIV transmission by blood and blood products. The modifications affect donor selection and deferral procedures, the HIV reentry algorithm, Public Health Service recommendations for additional medical follow-up and counseling, and the management of potentially infectious units from prior collections. For this reason, the FDA is issuing a revised set of recommendations which replaces the Agency's memoranda to blood establishments dated February 5, 1990 and December 5, 1990.

The FDA further discussed donor deferral criteria for HIV at a meeting of the Blood Products Advisory Committee on March 13, 1992. Based on updated scientific data which were presented at this meeting, modifications have been made to some of the deferral criteria. The changes include a 12 month instead of lifetime deferral for sexual partners of persons with high risk behavior, and voluntary instead of recommended use of Confidential Unit Exclusion. Also, the FDA is discontinuing its recommendation for documentation in the donor record of the medical history of HIV associated signs and symptoms.

* * *

RECOMMENDATIONS FOR THE PREVENTION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) TRANSMISSION BY BLOOD AND BLOOD PRODUCTS

Revised April, 1992

I. AIDS EDUCATION, SELF-EXCLUSION AND CONFIDENTIAL UNIT EXCLUSION

A. Educational Information to Permit Self-Exclusion

All persons donating blood or plasma for transfusion or further manufacturing use should receive both written information and oral explanation about the safety of blood products in relation to AIDS epidemiology and the implications for donors who have engaged in certain high-risk activities. Donors should not be considered suitable unless information about these risks can he communicated in the language appropriate to each donor (including appropriate communication to persons with impaired vision or hearing) and the educational format is constructed to be culturally sensitive to promote comprehension. The procedures applied should provide an opportunity at each visit for the donor to consider the information and to make an informed and private decision about whether to donate. In some settings it is appropriate to use abbreviated materials for frequent, repeat donors such as autologous donors or serial Source Plasma donors who may be screened as often as twice in a seven day period, and who are familiar with the program employed in the establishment.

Appropriately trained blood establishment personnel

should talk with each prospective donor about risk factors for HIV infection. The focus should be on behavior and not on stereotypes. For example, many men who have had male-to-male sexual experiences do not identify themselves as "homosexual," "gay," or "bisexual," but would identify with the description "sex with another man."

The direct questions concerning risk behaviors for HIV infection should be presented to potential donors orally, if possible. The technique demonstrated to be most effective by an FDA sponsored field trial included the use of an illustrated answer sheet for the donor to record a reply as the list of questions (see addendum) was read to the donor. The records for unsuitable donors do not need to include the answers to each of the direct questions about risk behavior, but may indicate that deferral was based on risk behavior history. If the questions are presented orally, the standardoperating procedures should ensure that questions are not abridged and each donor record should indicate that satisfactory responses were received. Each donor record should also accurately reflect staff responsibility for this portion of donor screening procedures and document the decision concerning donor suitability or deferral.

The educational material on AIDS should also include a description of HIV associated clinical signs and symptoms including:

- Unexplained weight loss
- Night sweats
- Blue or purple spots typical of Kaposi's sarcoma on or under the skin, or on mucous membranes
- Swollen lymph nodes lasting more than one month

- Persistant white spots or unusual blemishes in the mouth
- Temperature greater than l00.5 F for more than 10 days
- Persistent cough and shortness of breath
- Persistent diarrhea

It is not necessary for the donor record to include documentation of the donor history for HIV related signs and symptoms. It is necessary that donors be informed about HIV associated signs and symptoms so that they may self-defer if these conditions are present.

B. Criteria for the Exclusion of Unsuitable Donors Who Are at Increased Risk for HIV

The minimum information presented to potential blood and plasma donors at every visit should indicate clearly that persons meeting any of the following descriptions or having engaged in any of the following activities should not donate blood or blood components to be used for transfusion or further manufacturing:

* Persons with clinical or laboratory evidence of HIV (AIDS virus) infection.[1]

* Men who have had sex with another man even one time since 1977

---

[1]At this date, the most recent criteria from the CDC appear in MMWR 1987 ; 36(S-1) :1-9. A revision of these criteria is anticipated in the near future.

* Past or present intravenous drug users

* Persons with hemophilia or related clotting disorders who have received clotting factor concentrates

* Men and women who have engaged in sex for money or drugs since 1977 injury or accidental needlestick) or through contact with an open wound, non-intact skin, or mucous membrane during the preceding 12 months should be deferred.

* Persons who have had sex with any person meeting the above descriptions during the preceding 12 months .

* Persons who have had, or have been treated for, syphilis or gonorrhea during the preceding 12 months, or who have had a reactive screening test for syphilis in the absence of a negative confirmatory test in the last 12 months. (Any synonyms for these diseases that may be appropriate to the local donor population should be included in the donor questionnaire and oral interaction.)

[Note: Refer to FDA's memorandum to all blood establishments dated December 12, 1991 for additional discussion.]

* Persons who have received a transfusion of whole blood, a blood component (e.g. cryoprecipitated AHF, platelets) or a clotting factor concentrate (e.g., Factor IX, Human) within the past 12 months. Receipt of an FDA-licensed plasma derivative other than a clotting factor concentrate (e.g., Albumin [Human]) is not a basis for

exclusion.

* Persons born in or emigrating from countries where heterosexual activity is thought to play a major role in transmission of HIV-2 infection (i.e. sub Saharan Africa and islands located near these areas of Africa[2]) and persons who have had sex with any person meeting the latter description .

  [Note: These criteria should be discontinued upon implementation of a test for antibodies to HIV-2 no later than June 1, 1992.]

Sample direct questions on behavior related to increased risk of HIV infection are provided as an Addendum to this document.

During the health history interview, a donor may volunteer information about a specific instance of possible exposure to hepatitis viruses or to HIV. Suggested deferral periods for two such instances are provided below:

* Persons who have been victims of rape during the preceding 12 months should be deferred.

* Persons who have had contact with blood and body fluids through percutaneous inoculation (such as injury or accidental needlestick) or through contact with an open wound, non-intact skin, or mucous membrane during the preceding 12 months should be deferred.

---

[2]Sub-Saharan Africa includes all countries of Africa except Morocco, Mauritania, Algeria, Libya, Egypt, Tunisia, Sudan, Somalia and Western Sahara.

Donors should also be informed that:

* There is a time interval early in infection during which tests for HIV may be negative although an infection may still be transmitted .

* A sample of blood will be tested for antibodies to HIV and the donor will be notified if a test is positive (see I.C.l.c); individuals with positive tests will be permanently deferred from future blood or plasma donation.

* The names of people with repeatedly reactive tests for anti-HIV-l or anti-HIV-2 will become part of donor deferral registries (as required by 21 CFR 606 . 160 (e)].

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Q. You had said the subcutaneous injury before. Was that the right phrase?
A. It went into the tissue below the skin, yes.
Q. What about the other time that there was a sharp's injury?
A. I think it was a few months later she did the same thing.
Q. Anything else?
A. Not that I know of.
Q. Other than the needlesticks you just described, have you ever received any other type of sharp's injury while practicing dentistry?
A. Yes.
Q. Tell me about those.
A. I get sharp's injuries from explorers, knives, burs, sharp edges on partials, in particular, although occasionally a sharp edge on a denture, too. Amalgam saw.
MR. McCARTHY: I didn't hear that,
A . Amalgam saw. Sharp pieces of tooth and bone, matrix bands.
Q. I'm sorry, what?
A. Matrix bands. There's probably other things, but

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that's what comes to mind at the time.
Q. Approximately how many sharp's injuries of the type that you just described would you say you receive in a given year?
A. Probably several a week. Last week I had two in one day.
Q. And do these all occur while you are treating a

patient?
A. Those all can occur while I am treating a patient, yes, and those two last week that occurred on the same day occurred while treating a patient, different patients.
Q. And have you drawn blood in all of these injuries?
A. It's hard to quantify it. Most of them, yes.
Q. Have you taken any steps to reduce either the number of needlesticks that you have had occur or the number of sharp's injuries that have occurred?
A. Yes.
Q. What steps are those?
A. To try to pass the instruments so that the -- well, I try harder to protect my assistant and the patient than I do myself, because you can't achieve an optimum for everybody, so in consideration of that, I try to protect the patient and my assistant the most.

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Q. Have you taken any steps to reduce the number of needlesticks or sharp's injuries that you have received?
A. Yes
Q. And what are those steps?
A. One is that we, in as far as possible, don't handle the syringe until the patient is ready for the injection, try not to startle them, try not to inject when they don't seem like they might necessarily be cooperative. We -- the biggest single thing, and I think the reason that I do have a good record with this is that we stop everything when we are handling a syringe, nothing else is done, and nothing else is done until the needle is capped and the syringe laid down.
Q. How do you cap your needles?
A. One hand scoot.
Q. The sharp's injuries that you were mentioning just before from the explorers, the knives, the burs, the

amalgam saw and the like, do those mostly occur from -- while passing instruments or while you are working on the patient?

A. Mostly while working on the patient.

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Q. Dr. Bragdon, in your expert report at page two you indicate that in a hospital -- that you would treat an HIV positive patient in a hospital operatory with air filtration, is that correct?

A. Yes.

Q. And is the reason that you would need air filtration because of what you believe to be the potential transmission of HIV through aerosols?

A. Also HIV patients are at risk for other diseases such as TB.

DONALD MARIANOS, DDS 8-10-95

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(10) Q: What is a handpiece?
(11) A: A handpiece is the dental instrument that (12) is used to, in lay terms, drill the tooth. It holds (13) the dental bur.
(14) Q When the bur is being utilized, is there (15) some splatter from the patient --
(16) A Yes.
(17) Q -- that can reach the dental health care (18) worker?
(19) A Yes.
(20) Q Does that splatter include blood?
(21) A it can, yes.
(22) Q It's not unusual; is it?
(23) A It's not unusual.

* * *

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(5)Q Do you agree that the dental office staff (6) works in an environment where there is a frequent (7) spatter of blood and a blood-tinged saliva?
(8)A Yes.

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MANAGEMENT OF INFECTION IN HIV DISEASE
0891-5520/94 $0.00 + .20

From the HIV Infections Branch, Hospital Infections Program, National Center for Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia

INFECTIOUS DISEASE CLINICS OF NORTH AMERICA VOLUME 8. NUMBER 2. JUNE 1994

HIV TRANSMISSION IN THE HEALTH-CARE SETTING

Risks to Health-Care Workers and Patients

Laurie M. Robert, MS, and David M. Bell, MD

Evaluating the risk of HIV transmission in the health-care setting requires data from various sources, including surveillance activities that attempt to ascertain cases of HIV transmission to health-care workers (HCWs) and patients, seroprevalence studies among HCW's and patients, and prospective studies that evaluate a HCW's risk of seroconverting following an exposure to HIV-infected blood and that attempt to define the frequency and preventability of blood contacts in health-care settings.

TRANSMISSION FROM PATIENT TO HEALTH-CARE WORKER

Surveillance Data

Information on employment in a health-care setting is collected on AIDS case reports that are sent by state or local health departments to the Centers for Disease Control and Prevention (CDC). As of March 31, 1993, this information was available for 214,686 adults with AIDS; 10,122 (4.7%) had been employed in a health-care setting. In comparison, approximately 5.7% of the United

states labor force is employed in health services.[7] Of the HCWs with AIDS, 94% reported nonoccupational risks for acquiring HIV. The remaining 6% are reported as having an undetermined risk; most of these are still under investigation to determine the mode of transmission (C. Ciesielski, personal communication, 1993). HCWs who do not have another risk identified after follow-up investigation and who state they had previous occupational exposure to blood or body fluids are classified as cases of possible occupational transmission.

As of June 30, 1993, a total of 115 US workers have been reported to a national surveillance system for occupational transmission of HIV (Table 1). Thirty-seven workers had documented seroconversion associated with a documented exposure to HIV. Most of the exposures were to HIV-infected blood, one to visibly bloody fluid, one to an unspecified fluid, and one to concentrated virus in a laboratory. Thirty-two of the 37 workers had percutaneous exposures, four had mucocutaneous, and one had both percutaneous and mucocutaneous exposures. Eight of these HCWs have developed AIDS. Another 78 HCWs have been reported as possible cases of occupational acquisition of HIV. These workers did not report non-occupational risks for HIV and have reported occupational exposures to blood, body fluids, or laboratory solutions containing HIV; however, seroconversion was not documented, usually because no baseline sera were available to establish seronegativity at the time of exposure.[8]

This passive surveillance system for occupational transmission most likely does not reflect the full extent of occupational transmission; such cases can be difficult to document, particularly if exposures are not reported at the time of occurrence. In the past, it has been estimated that only 10% to 60% of percutaneous injuries are reported.[28,36]

HIV Seroprevalence Among Health-Care Workers

HIV seroprevalence surveys provide a means of indirectly assessing HCWs' risk of HIV infection (Table 2). CDC has sponsored two voluntary anonymous seroprevalence surveys of surgeons. In 1992, a serosurvey was performed among surgeons in three specialties practicing in moderate to high AIDS incidence areas.

Table 1. US HEALTH-CARE WORKERS WITH DOCUMENTED AND POSSIBLE OCCUPATIONALLY ACQUIRED HIV INFECTION, REPORTED THROUGH JUNE 1993

Occupation	No. of Cases of Documented Occupational Transmission	No. of Cases Possible Occupational Transmission
Dental worker, including dentist	-	7
Embalmer/morgue technician	-	3
Emergency medical technician/paramedic	-	7
Health aide/attendant	1	8
Housekeeper/Maintanence Worker	1	6
Laboratory Technician, Clinical	14	13
Laboratory Technician, Nonclinical	1	1
Nurse	13	15
Physician, nonsurgical	4	8
Physician, surgical	-	2
Respiratory therapist	1	2
Technician, dialysis	1	1
Technician, surgical	1	1

Technician/therapist, other than those listed above	-	3
Other health-care occupations	-	2
Total	37	78

Health-care workers are defined as those persons, including students and trainees, who have worked in a health-care, clinical, or HIV laboratory setting at any time since 1978. (From Centers for Disease Control HIV/AIDS Surveillance Report, July 1993.)

Table 2. PUBLISHED HIV SEROPREVALENCE IN SELECTED HEALTHCARE WORKERS

Occupation Author	No. Tested	No. Positive	Percent Prevalence*
Surgeons			
Panillo et al[40]	770	1	0.14
Tokars et al[52]	3420	2	0
Physicians and dentists (US Army Reserve)			
Cowan et al[16]	3347	3	n/a
Dentists			
Gerberding et al[22]	304t	0	0
Flynn et al[20]	89	0	0
Klein et al[34]	1132t	1	0.9
Siew et al[50]	1195	0	0.9
Gruninger et al[26]	1165	1	0.9

Gruninger et al[26]	1480	0	0
Ebbesen et al[19]	961	0	0
Dental hygienists			
Flynn et al[20] Klein et al[34]	167	0	0
Dental assistants			
Flynn et al[20] Klein et al[34]	176	0	0
Hemodialysis staff			
Assogba et al[3] Chirgwin et al[12]; Comodo et al[15]; Goldman et al[23]; Peterman et al[43]	356	0	0
Health-care worker blood donors			
Chamberland et al[10]	9449	3	tt

*Including seropositives with nonoccupational risk.
†Persons with community risk excluded
††One HCW lost to follow up

Among the 770 participants, one surgeon, did not report nonoccupational risks for HIV infection on an anonymous questionnaire, was HIV seropositive. This surgeon practiced general surgery for over 25 years and reported three percutaneous injuries involving patients with HIV infection or AIDS since 1978.[40] At the annual meeting of the American Academy of Orthopedic Surgeons in 1991, two of 3420 surgeons who participated in the survey were HIV seropositive; both reported nonoccupational risk factors.[52]

In a testing program conducted among physicians,

surgeons, and dentists in the US Army Reserve, who normally spend 90% of their time in civilian life, the HIV seroprevalence was 0 of 263 among men and 3 of 3084 among men. No other information regarding possible risk factors was reported for these seropositive men.[16]

No seropositives were found among 356 hemodialysis staff in five cities.[3 12 15 23 43] Three (0.03%) of 9449 HCW blood donors evaluated in six urban regions between March 1990 and May 1991 were HIV seropositive; two reported nonoccupational risk factors for HIV, and one was lost to follow-up.[10] Studies of dentists, dental hygienists, and dental chairside assistants have found low rates of infection among persons not reporting behavioral or transfusion risks (Table 2).[19 20 22 26 34 50]

A major limitation of HIV seroprevalence studies in HCWs to date is that the extent of occupational or nonoccupational exposure of most workers tested is not known. Also, some of these rates may be underestimates if workers who knew or suspected that they might be positive declined to be tested.

* * *

Table 16. Health care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through December 1996, United States[1]

Occupation	Documented Occupational Transmission[2]	Possible Occupational Transmission[3]
Dental worker, including dentist	-	7
Embalmer/morgue technician	-	3
Emergency medical technician/paramedic	-	10
Health aide/attendant	1	12
Housekeeper/Maintanence Worker	1	7
Laboratory Technician, Clinical	16	16
Laboratory Technician, Nonclinical	3	-
Nurse	21	28
Physician, nonsurgical	6	11
Physician, surgical	-	6
Respiratory therapist	1	2
Technician, dialysis	1	2
Technician, surgical	2	1

Technician/therapist, other than those listed above	-	5
Other health-care occupations	-	1
Total	52	111

[1]Health care workers are defined as those persons including students and trainees, who have worked In a health care, clinical, or HIV laboratory setting at any time since 1978. See *MMWR* 1992;41:823-25.

[2]Health care workers who had documented HIV seroconversion after occupational exposure or had other laboratory evidence of occupational infection: 45 had percutaneous exposure, 5 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures, and 1 had an unknown route of exposure. Forty-seven exposures were to blood from an HIV-infected person, 1 to visibly bloody fluid, 1 to an unspecified fluid, and 3 to concentrated virus in a laboratory. Twenty-four of these health care workers developed AIDS.

[3]These health care workers have been investigated and are without identifiable behavioral or tranfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids, or laboratory solutions containing HIV, but HIV seroconversion specifically resulting from an occupational exposure was not documented.

(Annals of Internal Medicine 1992; 116: 798-805)

Transmission of Human Immunodeficiency Virus in a Dental Practice

Carol Ciesielski, MD: Donald Marianos D.D.S., MPH; Chin-Yih Ou, PhD; Robert Dumbaugh, DDS, MPH; John Witte, MD, MPH; Ruth Berkelman, MD; Barbara Gooch, DMD, MPH; Gerald Myers, PhD; Chi-Ching Luo, PhD; Gerald Schochetman, PhD; James Howell, MD, MPH; Alan Lasch, DDS, MSPH; Kenneth Bell, BS; Nikki Economou, BS; Bob Scott, BS; Lawrence Furman, DDS, MPH; James Curran, MD, MPH; and Harold Jaffe, MD

- *Objective:* To determine if patients of a dentist with the acquired immunodeficiency syndrome (AIDS) became infected with human immunodeficiency virus (HIV) during their dental care and, if so, to identify possible mechanisms of transmission.
- *Design:* Retrospective epidemiologic follow-up of the dentist, his office practice, and his former patients.
- *Setting:* The practice of a dentist with AIDS in Florida.
- *Participants:* A dentist with AIDS, his health care providers and employees, and former patients of the dentist, including eight HIV-infected patients.
- *Measurements:* Identification of risks for HIV trans-mission (if present), degree of genetic relatedness of the viruses, and identification of infection control and other office practices.
- *Results:* Five of the eight HIV-infected patients had no confirmed exposures to HIV other than the dental practice and were infected with HIV strains that were closely related to those of the dentist. Each of the five had invasive dental procedures, done by the dentist after he

was diagnosed with AIDS. Four of these five patients shared visit days *(P*> 0.2). Breaches in infection control and other dental office practices to explain these transmissions could not be identified.

- *Conclusion:* Although the specific incident that resulted in HIV transmission to these patients remains uncertain, the epidemiologic evidence supports direct dentist-to-patient transmission rather than a patient-topatient route.

In July 1990, the Centers for Disease Control (CD(.) published the first of a series of reports describing human immunodeficiency virus (HIV) transmission from a health care worker to a patient (1-3). No case of such transmission had been previously reported, although transmission of another blood-borne pathogen, hepatitis B virus (HBV), from infected health care workers to patients has been well documented, and the theoretic possibility that HIV transmission could also Occur had been previously acknowledged (4-6). These reports intensified the ongoing debate concerning whether HIV and HBV-infected health care workers should do invasive medical and dental procedures. Resolution of this question has been hampered by the lack of accurate quantitation of the risk for transmission and also by misinformation and misconceptions regarding the likely mechanism of HIV transmission in the dental practice.

We review updated epidemiologic findings which led to the conclusion that five patients of a dentist with the acquired immunodeficiency syndrome (AIDS) were infected with HIV during their dental care. We also discuss the possible mechanisms of disease transmission.

Methods

The investigation began when a young woman without identified risk factors for HIV infection (Patient A) was reported to have AIDS. During a routine health department follow-up interview, Patient A provided the name of her dentist who, 2 years previously, had extracted her maxillary third molars. She was aware that the dentist had become ill and suspected that he might have AIDS. The dentist was known to the Florida Department of Health and Rehabilitative Services investigator as a previously reported AIDS case.

After publication of a report describing the possible HIV transmission to Patient A, the dentist publicly requested that his former patients seek HIV testing. The dentist was no longer in practice, and he could not provide a complete list of his former patients. However, a partial list was compiled from names provided by insura nce companies, Medicaid records, billing and other records from the practice, and from other dental offices in the area. Patients who had not been tested for HIV at the local county public health unit were notified by the Florida Department of Health and Rehabilitative Services. By the end of 1991. 2 of the approximately I 100 former patients tested were found to be HIV-seropositive (Patients B and C).

A fourth patient (Patient D) was identified by confidentially matching the names of the former patients to the state's reported AIDS cases. Three former patients (Patients E, G, and H) notified the Ct)(. that they were infected with HIV An-other patient (Patient F) was identified during the epidemeio-logic investigation of Patient E. which occurred between November 1987 and June 1989, included one examination, two prophylaxes, two cosmetic bondings, and one visit for extraction of her

maxillary third molars (Table 2). The patient recalled that the dentist wore gloves and a mask during the procedures. Dental x-rays taken during the spring of 1990 showed no additional extractions.

Medical records indicated that 4 weeks after the dental extraction, she was evaluated for a sore throat. She was afebrile, and her ulcerated tonsils and anterior cervical lymph nodes were moderately enlarged. The diagnosis was pharyngitis and aphthous ulcers; no indication exists that an acute retroviral syndrome was considered. She was diagnosed with oral candidiasis in May 1989 (17 months after the extraction) and with AIDS in December 1989 (24 months after the extraction), when she developed *Pneumocystis carinii* pneumonia. At that time, she was first tested for HIV antibody and was found to be seropositive.

Patient B reported that her only sex partner since 1978 was her husband, who tested seronegative for HIV. She denied injecting drugs.

Her 21 dental visits, between December 1987 and July 1989, included four extractions *(see* Table 2). Other procedures included three prophylaxes, three periodontal scalings, one examination, two restorative fillings, and ten fixed and removable prosthodontics. She recalled that the dentist wore gloves and a mask. She also recalled cutting her tongue on a tooth that was "sharply filed" during preparation for a bridge; however, she was unaware of any injury that the dentist may have sustained at that time.

Patient C denied having sex with men and injecting drugs. He reported multiple heterosexual partners but could name only 14 former female sex partners since 1978, and he was unaware that any were infected with HIV. Nine of these former partners were located and were found to be HIV seronegative The

possibility that Patient C had engaged in high-risk behaviors was raised during interviews and record reviews; however, behavioral exposures to HIV could not be documented.

He made 14 visits to the dental office between December 1984 and May 1989; the procedures included two extractions, two examinations, six restorative fillings, four prophylaxes, one periodontal scaling and one cosmetic bonding (see Table 2). Nine of these visits, including both of the extractions, occurred in 1984 and 1985, before the dentist began to wear gloves routinely (Figure 1). The patient did recall that the dentist wore gloves and a mask during his visits in 1988 and 1989.

Patient D, a man who had behavioral risks for HIV infection, was diagnosed with AIDS in 1989. He had 18 visits to the dental office between June 1985 and May 1989. The procedures included five examinations, five extractions, six prophylaxes, two periodontal scalings, four removable prosthodontics, and two restorative fillings.

Patient E denied injecting drugs. Of her ten known sex partners since 1978, two had died from non-HIV-related causes and were not known to be at risk for HIV infection. Each of the remaining eight was tested for HIV antibody; one was seropositive. This man (Pa-tient F) had other risk factors for HIV infection and was also a patient of the dentist. Patient E reported infrequent sexual contact with Patient F, the last contact occurring in the fall of 1988. Because of her concern about Patient F's high-risk behavior, she was first tested for HIV antibody in October 1988. Patient E was seropositive, whereas Patient F was seronega-tive

Billing records and receipts indicated that Patient E made 14 visits to the dentist between June 1988 and December 1988 *(see* Table 2). The procedures included

four examinations and radiographs, two prophylaxes, two root canal therapies, one restorative filling, six fixed prosthodontics, and one fluoride treatment. She reported that the dentist wore gloves and a mask during her visits.

Patient F tested negative for HIV antibody in October and December 1988, but he tested positive during the epidemiologic follow-up investigation in December 1990.

In September 1989, his medical records indicate a 1-week history of sore throat, loose stools, and headache; other symptoms included decreased appetite, fatigue, myalgia, and an earache. He had a temperature of 38.1 *C and tender anterior cervical adenopathy; his leukocyte count was 3300/[u]L, and he had a lymphocyte count of 693/[u]L. A diagnosis of tonsillitis was made, and a throat culture yielded "normal respiratory flora." No HIV-antibody test was done at that time, nor does any indication exist that an acute retroviral syndrome was considered. This illness occurred approximately 1 year after Patient F's last reported dental appointment (August 1988) and his last sexual contact with Patient E (Autumn 1988) and 9 months after his last negative HIV antibody test (December 1988).

Review of Patient F 's medical and other records established a history of behavioral risk factors for HIV infection. Only one dental visit was documented by billing records, although he reported five or six visits during July and August 1988 for examination, radio-graphs, prophylaxis,extraction, restorative fillings, and root canal therapy.

Patient G denied, since 1978, sex with men and injecting drugs. He first tested positive for HIV during screening for plasma donation in November 1990. He had been HIV seronegative when he donated blood in 1986, and his two reported female sex partners since 1986 were

HIV seronegative

Patient G's dental records could not be located, but records from an alcohol rehabilitation facility documented two visits in July 1988 for root canal therapy and a restorative filling *(see* Table 2). He could not recall whether the dentist wore gloves or a mask.

Patient H has acknowledged behavioral risks for HIV infection. He made three visits to the dentist between September 1985 and July 1986 for prophylaxes, examination, and gingivectomy.

With the exception of patients E and F, none of these patients named each other as a sex partner, and all denied sexual contact with the dentist. For all of the patients, local anesthesia _was the only anesthetic administered, and none could recall an injury to the dentist that would have exposed them to his blood (for example, a needlestick or a cut with a sharp instrument).

Laboratory Findings on Patients

The nucleotide sequences of the C2-V3 domain of the viruses from Patients A, B, C, E, and G were closely related to those of the dentist's virus. The average nucleotide variation ranged from 3.4% to 4.9% (50), a range similar to those previously observed for HIV strains from persons whose infections were known to be epidemiologically linked (7-9). In contrast, the viruses from Patients D, F, and H, each of whom had high-risk behaviors, were not closely related to the dentist's virus, and differed by 13.6% and 10.7% for Patients D and F, respectively (50). This degree of genetic difference has been found among strains of HIV that were epide-miologically unrelated. Preliminary analysis indicates that the virus from Patient H is also not closely

related to that of the dentist. No instance of comparable viral sequence relatedness was identified among the viruses from the 35 local controls (50). The HIV strains from patients A, B, C, E, and G were significantly closer in their DNA sequences to the dentist's virus than control patients *(P* = 6 x 10-[6], Wilcoxon rank-sum test) (50).

An unusual pattern or signature of eight noncontiguous amino acids encoded by V3 nucleotides was found in the dentist's virus. The viruses from Patients A, B, C, E, and G, had at least 7 of the 8 signature amino acids. This degree of agreement was not found in the viruses from the dental patients with behavioral risks for HIV infection, the local controls, or a reference set of sequences from 32 HIV-l strains *(P* = 8 x 10-[6], Wilcoxon rank-sum test) (50). This finding, together with the genetic distance analysis, suggests that the virus from the dentist and those from Patients A, B, C, E, and G formed a clusterof genetically similar strains that were distinct from the viruses of the patients with identified risks for HIV infection and from the viruses of 35 local control patients.

Interview with the Dentist

The dentist recalled having sustained needlestick injuries from anesthetic needles before he was diagnosed with HIV infection, but did not recall sustaining any percutaneous injuries after learning he was HIV positive.

The dentist reported nonoccupational exposures to HIV, and he believed that he had been infected through these exposures, although the exact time of infection remains unknown. He was unaware that any of his patients were infected with HIV, although he suspected that as many as ten patients may have been at risk for

HIV infection. He denied sexual contact with any of his patients.

Medical History of the Dentist

Review of the dentist's medical records showed that he was diagnosed with symptomatic HIV infection in late 1986 and with AIDS in September 1987, as indicated by a biopsy result diagnostic of Kaposi sarcoma of the palate and a CD4 + lymphocyte count of 190/[u]L. Zidovudine therapy was begun in early November 1987 but was discontinued from 16 December through 23 December 1987 because of neutropenia *(see* Figure 1). It was then continued at different doses throughout the time he remained in clinical practice.

In May 1988, examination of the palate showed purplish discoloration of the mucosa of the entire hard palate without ulceration or exophytic growth. The remainder of his physical examination was unremarkable. From 6 June through 20 June 1988, he received a total of 2750 rads of radiation therapy to his palate. This treatment resulted in mucositis at the end of therapy. By 6 July 1988, the palatal lesions had regressed, and the mucositis reaction had subsided. According to his medical records and interviews with his health care providers, he remained relatively asymptomatic except for fatigue until March 1989, when several lesions indicative of Kaposi sarcoma were noted on his abdomen and thorax. In June 1989, he was hospitalized with a presumptive diagnosis of P. carinii pneumonia. According to medical records, in the summer of 1989 his cutaneous Kaposi sarcoma lesions were treated with liquid nitrogen, and he reported that he used an electrocautery unit kept at his home to self-cauterize some of the lesions. In the

summer of 1989, he stopped practicing dentistry. During the time he was in practice, his medical records did not indicate thrombocytopenia or any other bleeding disorder, hand dermatitis, injury, or dementia. No indication of peripheral neuropathy was present, although no record of a detailed neurologic examination or testing for neurologic dysfunction was found in the medical records.

In October 1989, the Kaposi sarcoma progressed to involve his lungs, and he was treated with alpha-interferon and chemotherapy. He died in September 1990.

The Dental Practice

The dentist had a general practice at one location from 1981 to 1989. He was in solo practice except from September 1985 through February 1986, when he had an associate. In the summer of 1989, the office was sold to another dentist. The patient records were dispersed and many office records, such as appointment books, were discarded. The office was remodeled, and most of the dental equipment was replaced. The office staff stated that there had been no electrocautery unit in his office practice.

All 16 persons identified as having been employed in the dental practice, including receptionists, hygienists, and assistants, were located and interviewed. All tested seronegative for HIV antibody. Staff members were not aware of any patients who were known to be infected with HIV or of any who had been sex partners of the dentist.

Staff members reported that since 1987, the dentist had received one prophylactic treatment from the hygienist and on one or two occasions had had an

unspecified liquid medication placed on a palatal lesion using a cotton-tipped applicator that was then discarded. To the knowledge of staff members, the dentist received no other treatment and did not perform any treatment on himself in his office.

Infection Control Practices

Barrier precautions were fully introduced into the practice by early 1987; all staff with patient contact wore latex gloves and surgical masks for patient-care activities when appropriate. On most occasions, gloves were changed and hands were washed between patient contacts. Occasionally, however, gloves were washed rather than changed. Masks reportedly were changed infrequently. No staff member reported noticing any dermatitis or other lesions visible on the dentist or witnessing the dentist sustain a percutaneous injury during patient treatment.

By 1987, all surgical instruments used in the practice were autoclaved; other heat-tolerant instruments were autoclaved when time and instrument supply allowed or were immersed in a 2% glutaraldehyde solution for varying periods, usually of at least 20 minutes duration. Dental equipment such as prophylaxis angles and air and water syringe tips were either wiped with alcohol or immersed in 2% glutaraldehyde after each patient encounter. Some disposable items, such as saliva ejectors, high-speed evacuation tubes, and prophylaxis cups, were occasionally reused after being immersed in 2% glutaraldehyde, usually for at least 20 minutes. Hand-pieces were wiped with alcohol after each patient encounter; water lines were not flushed between patients.

The dental practice had no written infection control protocol or consistent pattern for operatory

cleanup and instrument reprocessing. No office protocol existed for reporting or recording injuries such as needlesticks or other percutaneous injuries involving sharp instruments or devices.

Only local anesthetic was used in this practice, and anesthetic needles were either recapped by the dentist using a two-handed technique or remained uncapped and were recapped by the assistant on completion of the dental procedure. By 1983, only single-use disposable anesthetic carpules and disposable needles were used. Staff members reported no instance in which a needle or carpule was reused on different patients; however, the same needle was routinely used multiple times on the same patient when multiple injections of local anesthetic were required. The dentist did not document his use of local anesthetic in patient records.

Days of Shared Visits

On four occasions, two of the five infected patients whose viruses were related to that of the dentist were seen in the dental office on the same day *(see* Table 2, Figure 1). Those with shared visit days included Patients A, B, C, and E; Patient G did not share any visit days with the other four patients.

The five patients made a total of 48 visits to the dental office from November 1987 until the close of practice in July 1989. To examine the likelihood that the five patients shared visit days, conditional probabilities were calculated based on the number of visits made by each patient between November 1987 and July 1989, the interval during which at least two of these five HIV. infected persons were patients of the dentist. The probabilities were calculated assuming that visits

occurred during days on which the dentist's office was open, without allowing multiple visits for the same patient on the same day. These shared-visit days probably occurred by chance alone ($P > 0.2$). Because appointment books no longer existed, neither the order nor the time of day could be determined for any of the shared-visit days.

Patients A and B were seen on 17 December 1987 *(see* Table 2). Patient A had two extractions while receiving local anesthetic. Patient B was examined for a toothache, and a radiograph was taken; no invasive procedures were done, although she had an extraction 4 days later. No indication exists that a handpiece was used on either of these patients on this day.

On 11 July 1988, Patient B had periodontal scaling and an extraction. Patient E had a crown placed on a maxillary bicuspid tooth. Patient B received local anesthetic, but we could not determine whether an anesthetic was used for placement of Patient E's crown because the tooth had previously had a completed root canal. It is unlikely that instruments used for the periodontal scaling and extraction would also be used to place a crown.

On 29 August 1988, Patient B had a bridge placed, and Patient E had plastic restorations placed on two maxillary anterior teeth. Although it is probable that local anesthetic was used on both patients on this day, the other instrumentation would differ. We could not determine whether the dental handpiece was used during the placement of the bridge; however, it would have been used for the restorations on patient E.

On 20 January 1989, Patients B and C had prophylaxes. Patient B's prophylaxis was done by thedental hygienist; however, we could not determine whether Patient C's prophylaxis was performed by the dentist or by the hygienist. It is unlikely that either

patient had local anesthetic administered on that day.

Discussion

The findings of this investigation led us to conclude that five patients of a dentist with AIDS became infected with HIV during their dental care. We support this conclusion because the five patients had no other confirmed exposures to HIV; all had invasive procedures done by the dentist; and DNA sequence analyses of the HIV strains from these five patients indicate a high degree of similarity among the strains and that which infected the dentist. These HIV strains were distinct from those infecting the three patients in the practice who had identified risk factors for HIV infection and from 35 HIV-infected persons residing in the same geographic area.

Our investigation is the first to report the transmission of HIV to patients during receipt of health care, although HIV transmission from infected patients to health care workers is well documented (10-12). In addition, transmission of HBV, another blood-borne virus, from infected health care workers to patients has been reported repeatedly since the early 1970s. More than 330 cases of HBV transmission from health care workers to patients occurring during invasive procedures have been reported (13-32) (Shapiro CN, CDC, unpublished data). Virtually all cases have involved clusters associated with care by 33 HBV-infected health care workers, including 9 dentists and 20 surgeons. Although percutaneous transfer of blood was the most likely mechanism of HBV transmission from health care worker to patient, the specific incident which resulted in transmission was not identified in any of the 33 episodes

investigated.

In none of these studies involving an HBV-infected surgeon or dentist was patient-to-patient transmission of HBV believed to have been a mechanism of transmission. However, in other health care settings, patient-to-patient transmission of HBV has been attributed to contaminated common-source vehicles, including jet guns, multidose vials of heparin and local anesthetic, and fingerstick devices (33-36).

Although the precise circumstances or mechanism of HIV transmission in this Florida dental office remains unclear, the preponderance of data support direct dentist-to-patient transmission rather than a patient-to-patient route. The dentist continued to do many invasive procedures after he was diagnosed with AIDS. This period includes the interval during which his zidovudine was discontinued and during which a course of radiation therapy was administered. All five patients had invasive procedures done after the dentist was diagnosed with AIDS and had evidence of severe immunosuppression. Low CD4 + lymphocyte counts are associated with higher viral titers in the blood (37) and therefore could be associated with an increased likelihood of transmission if an injury to the dentist occurred. In addition, interviews with the dentist's health care providers and his office staff indicated that, after he was diagnosed with AIDS, he frequently experienced fatigue, a factor which may have increased the likelihood of injury.

There were multiple opportunities for the dentist to have injured himself during invasive procedures done on these patients, especially during periods of fatigue and ill health. In a survey of self-reported sharps injuries in 89 dentists, 32% reported 2 or more per month, and 3% indicated more than 15 such injuries per month (38).

Another survey of 1132 dentists found a median of one sharps injury per month (39). Further, although undocumented, the possibility that the dentist had a peripheral neuropathy cannot be ruled out; peripheral nervous system dysfunction has been noted in 9% to 35% of patients with AIDS (40-43).

All five patients received multiple injections of local anesthetic, and a sharps injury during anesthetic administration could have resulted in contamination of the syringe apparatus with the dentist's blood, after which additional anesthetic may have been injected into the same patient. A sharps injury could also result in direct contact of the dentist's blood with the patient's inflamed or nonintact oral tissues during the invasive procedures. Although the dentist began to routinely wear gloves in 1987, gloves do not prevent most injuries caused by sharp instruments.

Human immunodeficiency virus does not remain viable for extended periods outside the body, and it is susceptible to commonly used germicides, including those used in the practice (4). Interviews of staff members indicate that, before use on patients, all instruments were cleaned and reprocessedby methods known to inactivate HIV, although these methods may not comply with recommendations designed to kill more resistant organisms.

If contaminated instruments or equipment are assumed to be the principal factor in these transmissions, one would expect to see a clustering of patient appointments. Although some shared-visit days were documented, these probably occurred by chance alone. Additionally, the procedures done on these shared visit days probably did not involve the use of the same instruments on more than one of the infected patients. Questions have been raised about the possible role of the

dental handpiece in these transmissions. It is unlikely that a high-speed dental handpiece was used on both patients on any of the shared-visit days, and, to date, no studies have confirmed the transmission of blood-borne viruses such as HIV or HBV through the dental handpiece or other dental equipment.

The dentist denied having sex with any of his patients. One HIV-infected person subsequently contacted the CDC and reported having had sex with the dentist in the early 1980s and occasionally receiving dental care from this dentist before moving from the area in 1985. However, no patient records exist to confirm these data. No other persons who were both sex partners and patients of the dentist have been identified.

The possibility that these infections were intentionally transmitted has been hypothesized. Interviews with family, staff, health care providers, patients, and others who knew the dentist have not provided any support for this hypothesis. The dentist initially cooperated with our investigation and provided a blood specimen for genetic sequencing to be compared with patients' specimens. Additionally, most of the procedures done by the dentist were routinely observed by staff, all patients were awake during the procedures, and no unusual behavior was noted or suspected by either patients or staff members.

Some have hypothesized that the dentist might have had an exceptionally high titer of virus or an easily transmittable strain of HIV. The titer of HIV in the dentist's blood obtained in March 1990 is currently being determined, although it is unclear how accurately this result would reflect the viral titer in his blood between 1987 and 1989. Strain-specific virulence factors for HIV transmission have not been identified; further, no evidence was found to suggest HIV transmission from

these patients to their sex partners.

The five patients identified in our investigation remain the only reported cases of HIV transmission from an infected health care worker to patients during invasive procedures. Results from six other studies of patients exposed to HIV-infected surgeons or dentists have not shown transmission (44-49). Of the 1246 patients of these health care workers who are known to have been tested, one was positive for HIV infection; however, this patient had behavioral risks for HIV infection and was probably infected before his surgical procedure (48).

The risk for transmission of blood-borne infections, including HBV and HIV, from an infected health care worker to a susceptible patient during an invasive dental or surgical procedure may depend on several factors, including the type of procedure, the infection control precautions, and the individual technique of the health care worker. The relative importance of these and perhaps other factors in predicting the risk for such transmission is poorly understood and requires further study.

Currently available information indicates that when health care workers adhere to recommended infection control procedures, the risk for transmitting HBV from an infected health care worker to patients is small, and the risk for transmitting HIV is probably even smaller. These small risks should not deter patients from seeking necessary surgical or dental care.

Table 1. Characteristics of the Dentist and the HIV-infected Patients Identified in the Dental Practice*

Patient	Identified Risk Factor for HIV	CD4 +/	MHA-TP FTS-ABS	HBsAg	Anti-HB_c
A	No	< 50	Negative	Negative	Negative
B	No	222	Negative	Not Done	Negative
C	Unconfirmed	< 50	Negative	Not Done	Negative
D	Yes	Not done	Negative	Negative	Positive
E	No	567	Negative	Negative	Negative
F	Yes	253	Negative	Negative	Negative
G	No	400	Negative	Negative	Negative
H	Yes	640	Negative	Positive	Positive
Dentist	Yes	190	Negative	Negative	Positive

*CD4+ = CD4 lymphocytes; FTA-ABS = fluorescent *Treponema pallidum* antibody absorption; HBsAg = hepatitis B surface antigen; anti-HBc = antibody to hepatitis B core antigen; MHA-TP = microhemagglutination assay for antibodies to *Treponema pallidum*.
[t] At initiation of epidemiologic investigation. [tt] At time of AIDS diagnosis.

Table 2. Dental Appointment Dates for Patients A,B,C,E, and G*

Year	Jan	Feb	March	April	May	June	July	Aug	Sept.	Oct.	Nov.	Dec.
1987/											A(16)	A&B(17)t B(21)
1988/					B(12)	E(18,23,30)	B&E(11) E(5,28) G(18,25)	B(1,4,8,16,16,18) B&E (29)t	B(1,8,23, 26) B(20) E(2,9,19)	B(20)	B(8) E(3,7,10)	A(23,29,30) C(6) E(8)
1988/	B&C (20)t	C(10,16)		B(10)	C(19)	A(29)	Practice Closed					

*Letters indicate patients; numbers in parentheses indicate day of the month
tShared-visit days.

(May 7, 1993 Vol. 42 / No. 17 MMWR 329)
Update: Investigations of Persons Treated
by HIV-Infected Health-Care Workers -United States

Previous reports have described transmission of human immunodeficiency virus (HIV) to five persons (patients A, B, C, E, and G) during receipt of care from an HIV-infected dentist in Florida (1-3) and other investigations of patients who were treated by HIV-infected health-care workers (HCWs) (4). This report updates these investigations and presents evidence that a sixth patient (patient I) became infected with HIV while receiving care at the Florida dental practice, the only practice in which HIV transmission from an infected HCW to patients has been documented.

* * *

Epidemiologic and Laboratory Investigation of Patient I

* * *

Interviews with the patient and her parents indicated that she was a patient in the dental office during the summers of 1987, 1988, 1989 for examinations, radiographs, prophylaxes, and restorative fillings under local anesthesia. . . . Bitewing radiographs taken in 1990 by another dentist indicate that single surface restorative fillings had been placed in three permanent molars. Before 1987, the patient had received no other dental care since the eruption of her permanent teeth.

* * *

Editorial Note: The results of the epidemiologic

and laboratory investigation of patient I indicate that she became infected with HIV while receiving care from an HIV-infected dentist. She had had no other confirmed exposures to HIV. In addition, DNA sequence analysis showed her HIV strain had a high degree of similarity to that of the dentist and the five other infected patients. The precise event(s) resulting in HIV transmission in this practice remain(s) unknown (1). Unlike the other five infected patients, patient I had neither dental extractions nor root canal therapy. Opportunities for injuries to the dentist were limited. However, exposure of patient I to the dentist's blood cannot be ruled out (e.g., related to use of the anesthetic syringe).

Approximately 1100 patients of the dentist are known to have been tested for HIV. In late 1990, HRS used available records to compile a partial list of the patients in the dental practice and notified those patients who had not been tested. Former patients who have not yet been tested should contact their local health department or private physician to discuss HIV testing.

Among the 58 investigated practices described in this report, the dental practice in Florida remains the only documented instance of HIV transmission from an HCW to patients. The risk for transmission of a bloodborne pathogen from an HCW to a patient is associated with the circulating titer of the pathogen in blood, the procedures performed, techniques and infection-control precautions used, and the medical condition ofthe HCW(9).

The results presented in this report are consistent with previous assessments that the risk for HIV transmission from an infected HCW to patients during invasive procedures is small and can be reduced with appropriate use of infection-control precautions (9,10).

(JADA, Vol. 124, October 1993)

HIV, HEALTH CARE WORKERS AND PATIENTS: HOW TO ENSURE SAFETY IN THE DENTAL OFFICE

JOHN A. MOLINARI, PH.D.

The professional relationship between many dental and medical health care providers and their patients has been modified substantially during the last 10 to 12 years.

Infectious diseases and irifection control have dramatically affected this change. The basic reasons did not involve well-known pathogens such as hepatitis B virus or herpes simplex virus, both documented as significant occupational risks for health care workers and, to a lesser extent, for patients exposed to infected health care workers[1-7]

Despite numerous reports on these and other infectious disease risks, the major catalyst for the change was the discovery and publication of a new form of life-threatening immune deficiency condition for which we did not (and still do not) have a cure--AIDS.[8,9] The door to widespread concern was opened further when what is now termed human immunodeficiency virus was isolated a few years later. [10-12]

Because of their bloodborne transmission potential, many organizations used both HBV and HIV as prototypical target microorganisms in developing infection control guidelines and regulations. These organizations included the Centers for Disease Control and Prevention,[13-16] the American Dental Association[17,18] and the Occupational Safety and Health Administration.[19]

What can be done to preserve the high standards of patient care, give reasonable assurances to patients and acknowledge the rights of health care workers?

Conscientious adherence to infection control is the most responsible option available.

HCW RISKS FROM HIV-INFECTED PATIENTS

Publication of detailed scientific information characterizing the structure, genetics and chemical susceptibility of HIV, its transmission, progression of infection and chemotherapeutic interventions did not provide all the answers to lessen people's fears. Extensive med'a coverage about HIV and AIDS, and publicity surrounding celebrities who died from complications of AIDS, caused many HCWs to ask a singular question: How much of an occupational risk do
we have when treating HIV-infected and AIDS patients?

Characterization of HIV structural antigens, marker antibodies, along with the development of increasingly sensitive serological assays, provided Opportunities to investigate suspected cross-infection cases. Despite thou-sands of reported accidental exposures, 33 occupational HIV transmissions were documented by the CDC as of April 1993, with 69 additional cases still under investigation (Table).[20]

A few important trends become apparent when reviewing these data:
- while not zero, the risk of HIV transmission to HCWs continues to be very small compared to other bloodborne infections such as hepatitis B;
- no documented HIV transmission to dental workers has yet been reported.

A very important portion of the findings indicates that 24 of 33 documented occupational HIV transmissions and 27 of 69 possible occupational HIV transmissions have occurred in either nurses or laboratory technicians.

Both groups routinely use hollow needles and collect blood specimens from patients. Blood has been the most common body fluid
involved in occupational HIV transmission to HCWs. Most reported health care injuries involve needlesticks or other sharps accidents.[20]

Recommendations from organizations like CDC incorporated this clinical knowledge into published recommenda-tions These recommendations emphasize the need for HCWs first to consider all patients as potentially infected with HIV or other bloodborne pathogens. Second, they call for rigorous use of infection control precautions to minimize the risk of exposure to blood and other body fluids of all patients.[21]

With specific reference to HIV risks for dental professionals, six cases have been investigated and are currently without identifiable behavioral or transfusion risks. In each instance, percutaneous or mucocutaneous occupational exposure to blood or other body fluids containing HIV was reported, but HIV seroconversion was not documented. A study carried out by the ADA as part of its annual session Health Screening Program suggested further that dentists are at small risk of occupation-ally acquired HIV infection.[22]

Though current data suggest a very low HIV risk for dental care providers, these data should not be interpreted as indicating no risk. Our routine aseptic, barrier, disinfection and sterilization infection control protocols have gone a long way in providing high standards of practice safety for both treatment providers and those receiving care. These standards should not be compromised just because HIV does not seem to be a significant occupational pathogen.

PATIENT RISKS FROM HIV-INFECTED HCWS

Studies investigating HIV risks for dental and medical professionals have been ongoing for years. Then the working environments of HCWs changed dramatically on July 27, 1990. On that date, the CDC reported the first instance of possible HIV transmission from an HIV-infected HCW to a patient.[23] People were stunned. Soon the case involving a Florida dentist was being discussed and debated in many forums. Later reports linking five additional patients to the dentist's HIV strain added to the turmoil and public concern.[24-26]

Unfortunately, the exact 'node of viral transmission has not been determined to date. It probably never will.[27, 28] Without important epidemiological information, the resultant extensive media attention and public proclamations of "instant infectious disease experts" have caused some health professionals and the public in general to draw conclusions based more on frustration, fear and anger than on existing scientific data. No matter what happened, the results have already been tragic for those infected, their families and society in general.

Central to the debate surrounding HIV-infected HCWs is what is considered an acceptable level of risk of HIV transmission. The CDC periodically publishes updated retrospective data on patients of HIV-infected HCWs.

In the most recent report, HIV test results have been completed for 19,036 people who were treated by 57 HIV-infected HCWs.[26] The findings from this investigation, and other recently published reports studying HIV-infected physicians and dentists,[29-32] have not found any other HIV transmission from an infected HCW to patients. The

Florida dentist remains the only documented case of HIV transmission from a treatment provider to patients.

Some elected officials have attempted to address this issue with proposed legislation that would mandate HIV testing for HCWs, and require those found to be infected to disclose their HIV status to patients. Many who work in the area of infectious diseases see substantial problems with this line of thinking.[33]

Any HCW-to-patient transmission of a bloodborne infection such as HIV or HBV would probably occur only within a narrow set of circumstances. Implementation of broad, potentially prohibitory regulations, therefore, does not appear warranted. At the least, many HCWs who believe they may be at risk for HIV infection would be tested anonymously, or avoid testing altogether. *As* a result, the regulations would succeed only in driving potential problems underground.

The risk of transmitting HIV from patient to HCW is much higher than the risk of transmitting from HCW to patient. For this reason, mandatory testing of HCWs is not defensible without a mandate that patients also be tested routinely. In addition, the period for developing positive serological reactions after HIV infection is long enough to suggest that regular retesting for infection be required. In effect, millions of scarce health care dollars would have t be diverted from effective HIV

* * *

(JOHN MOLINARI, P.h.D.)

Page 32

[2] Q: And you don't know of any evidence that
[3] supports the assertion that this was an intentional
[4] transmission by Dr. Acer?
[5] A: There was a friend, who went public, of Dr.
[6] Acer a couple years ago who claimed that Dr.Acer had
[7] some ill feelings against people and wanted to
[8] publicize the AIDS epidemic.This has never been
[9] corroborated. In fact, my understanding is that when
[10] this person was questioned by the CDC, there were a
[11] number of holes in that story.
[12] Q: It's correct, is it not, that HIV can be
[13] transnmitted more readily from a patient to a dental
[14] care worker than it can from a dental care worker to
a
[15] patient?
[16] MR. KLEIN: Object to the form.
[17] A: I would answer that the health care worker is
[18] generally the one with increased risk versus the
[19] patient when it comes to bloodborne disease.
[20] Q: (BY MR. MCCARTHY)And why is that?
[21] A: The health care worker is the one
[22] manipulating needles, sharp instruments, handling
[23] contaminated items in between patient care. The
[24] health care worker may be exposed to some sort of

Page 33

[1] sharps or percutaneous injury if the patient moves or
[2] flinches unexpectedly during some surgical or other
[3] procedure, and generally they are the ones who are on
[4] the receiving end of these types of accidents.
[5] Q: And that's why you say in your book that you
[6] wrote with Dr. Cottone and Dr. Terezhalmyn,
"Practical
[7] Infection Control In Dentistry," that the danger is
[8] much greater for dentists and dental care workers
than
[9] it is for patients.Am I correct?
[10] A: Correct.
[11] Q: Just for the reasons you've just recited?
[12] A: Correct.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

SIDNEY ABBOTT, |
|
Plaintiff |
|
Civil Action No. 94-0273-B
vs. |
|
|
|
RANDON BRAGDON, D.M.D., |
|
|
Defendant |

DECLARATION OF LEON R. KELLEHER, D.D.S.

Pursuant to 28 U.S.C. Sec. 1746, I, Leon R. Kelleher, declare that:

1. I sent a letter dated January 9, 1996, to Dr. Randon E Bragdon, a true and complete copy of which is attached hereto.

2. I hereby incorporate the complete text of that letter as if fully set forth herein.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief. Executed on March 27, 1996.

/s/

Leon R. Kelleher, D.D.S.

State of Illinois
County of , ss.

On this 27 day of March , 1996, before me personally appeared the above named Leon R. Kelleher and subscribed to the foregoing. .

OFFICIAL SEAL OF ILLINOIS

Notary Public
MY COMMISSION EXP. MAR. 9, 1998

Print name: Kathryn A. Seidel

RUSH PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER
RUSH UNIVERSITY
1653 West Congress Parkway, Chicago, Illinois 60612-3864
RUSH
SECTION OF DENTISTRY
Leon R. Kelleher, DDS. Director

January 9, 1996

Dr. Randon E. Bragdon
30 Judson Boulevard
Bangor, Maine 04401

Dear Dr. Bragdon:

We read with appropriate concern the recent (1-8-96) article in the ADA News regarding your alleged discrimination in the case of the HIV positive patient whom you proposed treat in a hospital operatory rather than your office in order to limit the risk of exposure to yourself and your staff. By this time we are certain that you have received letters of support for your position as well as some which are anything but that. Please allow us to add our names to the former list.

Our staff of seventeen dentists practices in a private instramural group which treats more than a hundred known HIV + patients. We share many of your concerns and frequently utilize "special facilities" or measures to assure our safety as well as that of the patient. Let me begin by assuring you that your obvious concerns as to

whether the CDC Guidelines regarding universal precautions are adequate to protect operator as well as patient do have merit. We invite your attention to the enclosed study by Drs. Robinson and Johnson of Stanford University which clearly shows that aerosols generated during the use of certain surgical instruments are contaminated. We are currently designing a study which is intended to show that the HIV can and does contaminate the aerosols generated by the dental high speed handpiece and the ultrasonci cavitron. Until the results of this study are ready for publication we do not intend to rely upon the assurances of the CDC or anyone else who purports that immersing ones head into an-infected aerosol is perfectly safe since it cannot be unequivocally proven that anyone has contraced HIV + in that manner.

In addition to the use of published universal precautions. our standard operating procedure is to avoid the use of aerosol producing instrumentation in known HIV+ cases. Patients who require dental prophylzxis are hand-scaled rather than cleaned ultrasonically. Patients on whom the use of the high speed handpiece is unavoidable are done with high volume evacuation under laminar flow conditions with hood or full face protection and remote air source for the operator. These procedures, of course, do not protect against the HIV+ patient who denies that status on his medical history or who does not yet know of his seroconversion or the patient who is HIV infected and who has not yet seroconverted. The question of whether all patients will eventually require treatment under these conditions remains academic until the results of these studies are finally published, repeated by others, and then disseminated to the profession. There will be no measure of consolation in being the first dentist to contract AIDS

through a contaminated aerosol.

It is somehow ironic that the very patients for whom we assume the most risk are usually the ones who respond to that humanitarian gesture with a lawsuit. One can only wonder whether these special interest groups whose primary banner is political correctness and whose efforts are usually behind the filing of such litigation will be there to support the cause of the first dentist or hy gienist who contracts AIDS from treatment of a patient and is denied disability coverage bv his or her insurer!

Good luck with your appeal.

Respectfully,

/s/

Dr. Leon R. Kelleher
Director
Section of Dentistry

(Journal of Medical Virology 33:47-50)

Human Immunodeficiency Virus-1 (HIV-1) in the Vapors of Surgical Power Instruments

Gregory K. Johnson and William S. Robinson
Divisions of Orthopedic Surgery (G.K.J.) and Infectious Diseases (W.S.R.) Stanford University School of Medicine. Stanford California

Cool vapors and aerosol produced by several common surgical power instruments and not smoke plumes generated with electrocautery or known HIV-1 innoculated blood were gentlybubbled through sterile viral culture media. Tissue culture cells were then added and cell infection was detected by the appearance of HIV-1 P-24 core antigen assayed by ELISA in the culture medium. HIV-1 was cultured from cool aerosols and vapors generated by a 30,000 RPM spinning router tip, an instrument similar to *the* Midas Rex and the Stryker oscillating bone saw. No infectious HIV-1 was detected in aerosols generated by a Valley Lab electrocautery or with a manual wound irrigation syringe known as a Travenol Uromatic irrigator We have demonstrated that HIV-1 can remain viable in cool aerosols generated by certain surgical Power tools and this raises the possibility of HIV transmission to medical personnel exposed to aerosols similarly generated during the care of HIV infected patients. Further work is required to determine whether such a risk exists but caution should be exercised by those exposed to aerosols generated during procedures on HIV-1 infected patients,

INTRODUCTION

Surgeons and other health Care workers are routinely exposed to significant and often prolonged aerosols generated by certain Orthopedic and surgical procedures on bone, soft tissue, and body fluids. When the tissues contain infectious ag ents, there is a Possibility of transmission of the agent to personnel exposed to the aerosols. For example, papilloma virus DNA has been isolated from laser plumes from papilloma lesions, and nasal papillomas are seen to develop in the noses of physicians and operating room staff cumulatively exposed to laser/papilloma Plumes [Garden et al., 19881.

Although HIV-1 appears to be transmitted most frequently by sexual contacts, and by percutaneous and perinatal exposures [Weiss et al., 1985; Melbye. 1986 Henderson et al., 1986: Friedland and Klein. 1986] there is a report of a laboratory worker possibly but not proven to be infected with HIV- 1 by aerosols generated by ultracentrifugation or other manipulation of large quantities of cell culture medium containing tissue culture adapted HIV-1 strain HTLV III [Weiss et al., 1988; Barnes. 19881. That case raises the possibility that individuals might be infected with HIV 1 when performing procedures which strongly aerosolize materials containing infectious HIV. The purpose of this study was to determine if infectious HIV - 1 could be isolated from aerosols generated from human blood containing HIV-1 by common orthopedic and surgical procedures known to cause aerosols.

* * *

DISCUSSION

These experiments show that infectious HIV-1 can be isolated from cool aerosols created from blood

containing HIV-1 exposed to certain surgical power instruments such as a high speed spinning router (analogous to the Midas Rex) and the Stryker oscillating bone saw. Careful inspection revealed that no liquid or solid material passed through the small (2 mm) diameter 20 in length of tubing used to transfer the aerosol generated by these instruments within the canister to the test culture medium, indicating the virus retained surncient infectivity in aerosols generated in this way to infect MT-2 cells in culture. Experiments with noninfected blood, utilizing an industrial quartz-crystal impacter, quantitated the large quantity of micron and submicron aerosols generated with each of our procedures.

The Uromatic syringe wound irrigator device, which can also be expected to generate cool aerosols less efficiently, did not result in positive cultures as strictly defined here, indicating that aerosols created in this way did not contain enough infectious HIV-1 to be detected in the assay used. The electrocautery in either coagulation or cutting mode created visible smoke plumes which were suctioned through culture medium, but no infectious HIV-1 could be detected, raising the Possibility that high temperature of cautery may have inactivated HIV-1

Although these experiments show that HIV-1 retains infectivity in aerosols generated in certain ways, they do not quantitate the risk of HIV transmission to personnel by such aerosols generated under clinical conditions, e.g., in the operating room. The failure to detect HIV-1 in aerosols generated by certain procedures (e.g., cautery or syringe jet) in our experiments does not exclude the possibility of clinical transmission by such procedures. Several variables could influence the risk of such transmission in a clinical setting. The concentrations of HIV in tissues arid body fluids appear

to vary widely in different infected patients and HIV is often cell associated. However, extracellular infectious HIV-1 in moderately high concentrations has been detected in plasma of at least some patients [Ernst et al., 19881. The dose of the w ild type HIV stra ins that might be necessary in an aerosol form to infect via respiratory or mucosal surfaces_exposed to such aerosols, and whether such a dose can ever be generated in clinical situations are unanswered questions. Although our experiments raise the possibility that infectious HIV could be present aerosols generated in clinical practice, the large body of epidemiologic data on prevalence of HIV infections in different Populations [Weiss et al., 1985; Melbye, 1986; Henderson et al., 1986; Friedland Klein, 19861 would suggest that transmission by aerosols is not common. However, there are no published studies precisely examining medical or dental personnel most heavily exposed to aerosols generated in care of HIV infected patients compared with appropriate controls, and such studies would seem desirable based on our findings., There are studies showing that HBV seroconversion is higher in surgical and dental personnel even controlling for penetrating injuries, a result not inconsistent with an aerosol route of infection in some cases [Dienstag and Ryan, 1982]. An experimental approach that might provide some direct information about aerosol transmission of HIV would be exposure of chimpanzees to aerosols potentially containing HIV generated under conditions simulating different clinical procedures that create aerosols, or the use of some other model system such as simian immunodeficiency virus (SIV) and susceptible non-human primates for such experiments. Further work is also needed to better quantify the nature and size of the aerosol particles which can sustain infectious HIV and the length of time the

virus remains viable in aerosol form.

In the absence of definitive studies proving that aerosols in clinical settings pose no risk of HIV transmission to personnel, surgeons, dentists, and others should avoid techniques which generate such aerosols or even smoke plumes with patients known to be infected with HIV. Where such procedures are unavoidable, personnel should consider using high efficiency filtration masks and systems for containing aerosols.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

SIDNEY ABBOTT,
Plaintiff

Civil Action No. 94--0273--B

vs.

RANDON BRAGDON, D.M.D.,
Defendant

SECOND DECLARATION OF SANFORD F. KUVIN
M.S., M.D., D.T.M. & H.

Pursuant to 28 U.S.C. Sec. 1746, I, Sanford Kuvin, declare that:

1. I hereby incorporate as if fully set forth herein par. 1 of my September 14, 1995, Declaration in this action. Based upon my education, experience and expertise, I offer the following declaration and opinions.

2. Both the blood and the saliva of an HIV--positive patient contain the human immunodeficiency virus (HIV). There is no scientific evidence that a dentist can become infected with HIV through contact only with saliva from an HIV--positive patient. However, there is scientific evidence that a dentist can become infected with HIV through contact with blood or bloody saliva from a patient infected with the virus that causes AIDS. Transmission of HIV from a patient to a dentist can also certainly occur, for example, if a drop

of bloody saliva, in splatter or in aerosol form, makes contact with a mucous membrane of the dentist such as the eye, the nose or the throat.

3. Page five of Ms. Abbott's brief quotes page 55 of my deposition out of context and thereby tries to suggest that no aerosol transmission of HIV is possible. That is patently false, since it does not differentiate between blood or bloody saliva in aerosol form, and saliva unzuixed with blood, in aerosol form. The context of my deposition, pages 55-59, and especially pages 58-59, makes this clear.

4. Page eight of MS. Abbott's brief wrongly implies that there is no risk of HIV transmission from patient to patient in the dental office. In view of current technologies, the transrnission of viruses and bacteria can occur through the transmission of bloody saliva that has retracted into a water line arid then passed to a subsequent patient. In addition, transmission can occur through infrequent, but inevitable break downs in universal precautions, as, for example, when a previously contaminated needle, handpiece, or other instrument is not properly sterilized or disposed of. Universal precautions, when properly and thoroughly employed, help to reduce the risk of transrnission of HIV, but they do not eliminate the risk.

5. Universal precautions simply do not equate with universal safety. The inexplicable transfer of clusters of hepatitis a virus ("HBV") to patients that have occurred during invasive medical procedures when universal precautions were diligently employed attest to this fact. HBV is a bloodbcrne virus spread by identical methods as HIV.

6. The recently published article by David Lewis and Max Arens in the prestigious peer reviewed journal Nature Medicine (attached as Exhibit 7 of Dr. Bragdon's Motion for summary Judgment) indicates that the risk of transmission of HIV from patient to patient in dental of fices may be greater than many experts *had* previously suspected.

7. Tuberculosis (TB) is spread casually by droplet infection.

8. The CDC states in the attached excerpt from MMWR that HIV infectior. is the strongest risk factor yet identified for the development of TB disease in persons having TB infection, and that 811 H:V-inf ected persons should receive a PPD-tuberculin skin test in *settings* where HIV-infected persons receive care.

9. The CDC recommends that all persons with HIV be suspected of having TB and that they may be referred to an appropriately engineered facility (e.g., one with ultraviolet germicidal irradiation and high-efficiency part culate air filtration (HEPA)) for dental treatment involving cough-inducing or aerosol-generating procedures.

10. The CDC's recommendations regarding TB and HIV in the dental setting are, if not logically inconsistent, certainly are in tension with one another. This tension may be the result of (i) the political and civil rights atmosphere surrounding H:v that has led the CDC to downplay the *risk* of transmission of HIV, and (ii) the absolutely non-political, non-civil rights atmosphere of tuberculosis. However, since the CDC's

recommendations regarding TB in the dental setting are of more recent origin than the CDC's last official pronouncement regarding HIV in the dental setting, it may also be the case that the CDC is finally in the process of beginning to deal more responsibly with the gravity of the issue of HIV in the dental setting. TB is a reportable disease in Maine, but HIV is not.

11. Based upon and consistent with CDC recommendations regarding TB, Dr. Bragdon could, as a general rule, decline to perform cough-inducing or aerosol-generating dental procedures (such as filling a cavity) on any HIV positive person in his office on grounds that he or she can reasonably be suspected of having active TB and should receive such treatment in an appropriately engineered facility, as recommended by the CDC.

12. Based upon the conf licting recommendations of the CDC regarding HIV in the dental setting, a dentist might also reasonably decide to discount the possibility of active TB in an HIV-positive person who does not seem infectious with active TB. *A* more conservative approach, however, would be for the dentist to adopt a general policy of referring all cough-inducing, or aerosol-generating, procedures on HIV-positive patients to an appropriately engineered TB facility. This is because, among other things, it is quite difficult to diagnose active TB in a person with HIV. People with HIV often show false negatives for active TB when given the customary tuberculin purified protein derivative (PPD) test. Even chest x-rays often fail to reveal active TB in a person with HIV. And simply because a person looks healthy and is not coughing does not mean that she does not have active TB.

13. Because it is difficult, if not impossible, for a dentist in his office to diagnosis active TB in a person with HIV, and because people with HIV are at high risk for active TB, the CDC's recommendation that all people with HIV who are to undergo cough-inducing or aerosol-generating dental procedures should be considered infectious with TB, makes medical sense, as does the automatic referral of *such* cases to an appropriately engineered dental facility.

14. TO the best of my knowledge, no CDC publication has ever concluded that dentists should perform invasive dental procedures on HIV-positive patients ill the office setting. Instead, the CDC has carefully limited itself to the unremarkable conclusion that such procedures "can" or "may" be performed safely with the use of universal precautions, and that additionalprecautions are therefore "unnecessary."

15. To the best of my knowledge, no CDC publication, or any reliable, published authority, has ever concluded that the risk of transmission of HIV from patient to dentist using universal precautions during an invasive procedure is infinitesimal. The CDC characterizes the risk as "small."

16. Because of the dearth of comprehensive, scientific studies on the issue, some authorities conclude that the risk of transmission of HIV from patient to dentist cannot be accurately *quantified.* While this is arguably true, some fairly reasonable estimates can nevertheless be constructed from available, although limited, data. For example, the average dentist performs approximately 3,000 invasive procedures per year (in contrast to 500 for

the average surgeon), and Dr. Greenspan reports an average of 1.5 needle-stick injuries per 100 infections given by dentists. See Greenspan Dep. at *156-159.* The CDC now estimates that the rate of fatal outcomes from percutaneous injuries causing contact with contaminated blood is approximately 3 per 1000. Not all needle-stick injuries to dentists result in parenteral exposure to a patient's blood. Assuming only 1 in 3 *such* injuries result in such exposure, the risk of a dentist receiving a fatal needle-stick while giving one injection to a single HIV-positive patient is (1.5/100) x (1/3) x (3/1000), which is equal to 4.5/300,000, which is equal to 1/66,667. According to calculations provided to me by Professor Halteman (attached), this means that if a dentist practices for 30 years, and gives an average of 235 injections per year to HIV-positive patients, that dentist has more than a 10% chance of sustaining at least one fatal, HIV needle-stick injury during that time. In addition, if the dentist gives only 5 injections per year to HIV-positive patients for 30 years, the dentist has more than a 50% chance of sustaining at least one percutaneous exposure to HIV-infected blood, which is a life-threatening event.

17. The method employed in the previous paragraph to estimate the risk to dentistsfrom accidental needlesticks accords entirely with the method employed by Dr. David Bell from the CDC to estimate the risks to patients from HIV-infected surgeons. The Fourth Circuit relied upon Dr. Bell's estimate in & case called Doe v. University of Maryland Medical Systems Corp., 50 F.3d 1261, 1263 (4th Cir. 1995). I served as an expert witness on behalf of the hospital in that case. We know that the dental profession is more invasive than the practice of most surgeons, and that blood is a two-way street.

18. The estimate in the next to the preceding paragraph does not take into account the additional risk of percutaneous injuries to dentists caused by the dental bur and other sharps. Nor does it take into account the additional risk of exposure to blood or bloody saliva in aerosol form that penetrates mucous membranes or nonintact skin. The estimate in the preceding paragraph is theref ore a conservative estimate

19. Dr. Craven is wrong in his Affidavit, ¶¶ 7-10, to imply that sorriehow the risk of transmission of HIV from patient to dentist is less than one in a billion. This analysis is severely flawed for several reasons.

a. Of his estimated 1e4 billion to 2.8 billion dental procedures in the United States since 1982, only a small percentage of them were performed on people with HIV It is patently fallacious to imply that the risk of transmission of HIV from patient to dentist is low because patients without HIV have not transmitted HIV to their dentists.

b. Dr. Craven incorrectly states that the CDC has monitored the occupational transmission of HIV from patients to dentists When a person with HIV goes to a dentist, knowingly or unknowingly, it is not reported to the CDC. When a dentist sticks himself with a needle, or has a sharps injury, it is seldom reported to the CDC. Various institutions do have rules for the reporting of needlesticks, and studies have shown that underreporting of needlestick injuries range from 70% to 95%. See AIDS Clinical Care, Vol. 5, No. 10, p. 78 (Oct. 1993). The CDC has also cited 1983 and 1991 studies for the view that as few as 10% of percutaneous injuries are reported. See Ex. 1 of Dr. Bragdon's Motion for Summary Judgment, p.

320.

One of those studies cited by the CDC, which is a reliable authority found in the American Journal of Medicine, is attached. The authors state that failing "to report exposures to HIVinfected blood leads to an inaccurate estimation of prevalence and a subsequent underestimation of the overall occupational risk of acquiring HIV infection" and that the "reported circumstances of exposure suggest that compliance with current infection-control procedures will not prevent many needlestick injuries." Based on their data, the authors extrapolated that approximately 1 in 1,000 medical interns will become infected with the AIDS virus during only 12 months of *working* in hospitals as a result of accidental needlesticks.

OSHA regulations require dentists to keep records of sharps injuries suffered by their employees, but the regulations do not require that the records be sent to OSHA, much less to the CDC. See 29 CFR Sec. 1910.1030(h)(3).

c. In reality, what the CDC euphemistically refers to as its "passive surveillance system," Ex. 1 of Def.'s Mot. for Summ. J., p. 320, is that every once in a while a dental worker who has reason to suspect he or she has been infected by an accidental exposure to HIV-infected blood has, for whatever reason, decided tocontact the CDC. According to page 1238 of a CDC article in the September 1995 issue of JADA (attached as Ex. la to Dr. Bragdon's opposition memorandum), this type of voluntary disclosure has happened 19 times. Then, if the dental worker is immediately tested for HIV and is negative, and later tests positive in one to six

months, and has no other risk factors, he or she becomes a documented case of HIV transmission. If he or she has no other risk factors, but is not immediately tested and then tests positive in one to six months, he or she becomes a possible" case of occupational transmission. There have been 6 such "possible" occupational transmissions to dental workers out of only 19 reported exposures. See id., Ex. 1a at 1240. Thus, almost 1/3 of all reported exposures for dental workers are cases in which dental workers have *HIV,* and no other identifiable risk factors apart from accidental occupational exposures. With other, non-politically charged infectious diseases such as hepatitis B, the practice in the medical profession has been to treat analogous "possible" cases as actual cases, and to make policy accordingly.

d. Dr. Craven's analysis, which is based only upon the lack of any CDC documented occupational transmission of HIV to a dentist, necessarily overlooks the risk of HIV transmission from blood, or bloody saliva, in aerosol form. in fact, there are over twice as many CDC reported cases of HIV-infected health care workers without any identifiable non-occupational risk factors, but whose Source of HIV-infection is officially unknown (91 such cases), than there are CDC documented cases of occupational transmission of HIV to health care workers (42 such cases).

20. Ms. Abbott's brief on page 11 wrongly implies that I believe Ms. Abbott would have a ten percent risk of acquiring an infection just from having her cavity filled as an outpatient in a hospita1. The ten percent figure discussed during my deposition is for patients who are in ahospital for a prolonged stay, and not for the relatively brief stay of a dental outpatient visit.

21. As a matter of medical ethics, I believe that Providing routine dental care to HIV-positive patients is not so inherently dangerous that dentists should not be required to provide such care. However, page 11 of Ms. Abbott's brief incorrectly implies that I believe Dr. Bragdon should be compelled to treat Ms. Abbott in his dental office. The context of my statement during my deposition, pages 188-189, shows that I also believe as a matter of medical ethics, that Dr. Bragdon should have the right to exercise dental and medical judgment about where and how to treat his patients in a Professionally confident, comfortable, and comprehensive setting. As a matter of law, because of the significant risk to Dr. Bragdon, I believe that *he* cannot and should not be compelled against his will and judgment to perform such invasive procedures in his office.

I hereby declare under penalty of perjury that the foregoing information *is* true to the best of my knowledge and belief.

Executed on October 4 1995.

OFFICIAL NOTARY SEAL
PUBLI MOLLIE GUTIERREZ
Sanford F. Kuvin,M.D. did personally

COMMISSION NUMBER
CC202490
appear before me on this day and being perso nally known to me.

MY COMMISSION EXP.
JUNE 21 1996

/s/

Mollie Gutierrez,Notary

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE-

SIDNEY ABBOTT,
Plaintiff Civil Action No. 94-0273-3
vs.

RANDON BRAGDON D.M.D.,
Defendant

AFFIDAVIT OF ARLEEN RICHMAN

The affiant Arleen Richman, being duly sworn deposes and says:

1. My name is Arleen Richman. I am of legal age and under no legal disability.

2. I am the Director of Communications of the United States Parachute Association (USPA), 1440 Duke Street, Alexandria, VA 22314. In my capacity as such, I have personal knowledge of the facts stated in this affidavit.

3. Since 1984, it has been the regular practice of the USPA to compile the statistics concerning the number of deaths per jump that are contained in the attached table for years 1984 to 1992. These statistics are derived from inf ormation received from people with knowledge of the relevant numbers of jumps and associ ated skydiving fatalities, and who keep such information in the regular course of their skydiving associations. The statistics concerning the number of deaths per jump for years 1984

to 1992 were complied at or near the time such information was received.

/s/
Arleen Richman

DATED: September 29, 1995

STATE OF *VIRGINIA*
Date Sept. 29, 1995

Personally appeared the above-named Arleen Richman, who first being duly sworn, made oath that the foregoing affidavit which she has signed and to which she subscribed is based on her personal knowledge and that the facts set forth therein are true.

Before me,

/s/

Name: Notary Public

My Commission Expires as September 30, 1999

SKYDIVING AT GLANCE

United States Parachute Association *(USPA)*

(703) 836-3495

WHO SKYDIVES? You're in good company - USPA membership is slightly over the 29,000 mark and growing by about 5% a year. About 12-15% of our members are women. More than 90% of our members have a high school diploma; 40% are college graduates. Members range in age from *16* - (permissable at some Drop Zones) to well into their 70's and 80's.

CAN ANYONE JUMP? Almost anyone can successfully complete a first jump. No experience is required. Individual skydiving centers, called Drop Zones or DZs, set their own guidelines. Generally, you need to be in good heatth, age 18 (16 with parental consent, if DZ policy allows) and weigh no more than 225 pounds.

HOW DO I START? USPA recognizes 3 types of first jumps:

Tandem: Student is attached to the front of the Instructor's harness and is carried as a passenger throughout the jump from exit until landing. Requires minimal ground school.

Static Line: You exit solo from the aircraft. Your chute is automatically deployed as you exit the plane at about 3,000 feet. Requires ground school and attaining learning objective.

AFF: Two Jumpmasters exit the aircraft holding on to you (one on each side) and assist (Accelerated you while you freefall for about 45 seconds. Once you open the

parachute, the Freefall) Jumpmasters leave and you make a solo descent. Requires classroom instruction prior to first jump. This training program progresses through 7 levels of instruction, at which time you should be well on the way to meeting the requirements for your "A" license.

WHERE: At a Drop Zone that is a Group Member of the USPA, USPA Group members have. pledged to follow USPA Basic Satety Requirements and Recommendations for student and advanced skydivers and to offer first-jump courses taught by USPA rated instructors. See the attached listing for the Centers nearest you.

HOW MUCH: Expect to pay between $150 and $200 for a first tandem or static line jump. First time freefall costs between $250 and $300. Fees Include all equipment and training. Experienced skydivers (those who jump without instruction) can jump for between $6 and $20 depending on type of aircraft used and altitude of exit.

THE RISK: Parachuting has an Inherent risk but new and modern equiprnent, improved techniques, and USPA certified instructors have sharply reduced most of the dangers. Annual rate of fatalities is usually between 26 and 30 or approximately 1.2 in 100,000 jumps.

TO ENHANCE YOUR SAFETY:

*Plan to make your first jump at a USPA Group Member
*Ask to see the instructor's USPA rating "Use an Automatic Activation Device (AAD) required by USPA's Basic Safety Requirements "Check out the Drop Zone BEFORE you jump. How exprienced are the pilots and how well maintained are the planes? What

feeling/attitude do you get when you visit the DZ? Does safetyseem to be eveyone's first concern?

Blue Skies!!!!!! Hope to see you up there soon!!
Any Questions- call 703-836-3495.

Although skydiving is statistically a safe sport, it is inherently dangerous, with the proper training and equipment the risk can be minimized.

Year	Participants	Jumps	Fatalities	Deaths per Jump*	Deaths Per Participant*
1983/	101,500	UKN	29		28.5
1984/	100,300	2,373,000	33	1.2	32.9
1985/	102,100	2,329,000	26	1.1	25.5
1986/	105,600	2,246,000	30	1.3	29.4
1987/	108,200	2,289,000	28	1.2	25.9
1988/	110,700	2,297,000	23	1	20.8
1989/	111,880	2,352,000	36	1.5	32.2
1990/	115,500	2,400,000	23	0.9	19.9
1991/	121,900	2,440,000	30	1.2	24.6
1992/	136,528	2,600,000	27	1	19.7

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5 YEAR AVERAGES

YEARS	PARTICIPANTS	FATALITIES	DEATHS PER PARTICIPANTS*
87-91	113,536	28	24.6
82-86	104,250	29.4	28.2
77-81	108,940	49	44.9
72-76	99,000 est	40.6	41.0 est

All accidents 34.9*
motor vehicles (ages 25-44) 32.0*
in 33 states the accidental death rate is g eater than 35 deaths per 100,000 population
*** based on ratio of deaths per 100,000 (jumps or participants)**

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DESIGNATED AIDS CARE CENTERS

RANDON BRAGDON, D.M.D.

It has been well demonstrated and documented that persons that are HIV- or have full blown AIDS get the best care in settings where they are able to get specialized care by health care professionals.

The largest AIDS dental clinic in New York City treated 3,000 patients last year. In talking to professionals who are familiar and/or work iwth these designated AIDS Care Centers, they work well and are well liked by the AIDS patients themselves. This is hardly surprising as just about everyone likes to get the best possible care.

The state of New York with its extensive treatment of AIDS patients in New York City in the early 1980's, soon determined that simplistic crisis oriented approach to AIDS care did not work very well. As a result, in 1986 the State of New York instituted Designated AIDS Care Centers. There are now twenty-three of these AIDS Care Centers include dental facilities which are able to provide comprehensive care. The remaining one-forth of the Designated AIDS Care Centers also have dental facilities, but they could not be described as completely comprehensive. It is their goal for all such dental AIDS facilities to be able to provide comprehensive dental care.

In about 74% of the Designated AIDS Care Centers, the AIDS patients are kept in AIDS units. This puts to rest the myth that AIDS patients cannot have their own ward and that nurses cannot know who they are. In two centers combination of AIDS unit/ scatter beds is used and in three centers scatter beds are used.

They have found that the coordinated AIDS multidisciplinary team with the continuum of care model has worked well. Not only do the AIDS patiens receive better quality care, but the number of in-patient hospital days per patient has been reduced dramatically. As a result, the centers receive enhanced per diem reimbursement rates.

The twenty-three centers treat about 40% of the NYS AIDs patients. NYS took the successful AIDS Center approach because their extensive experience proved that AIDS patients have a multitude of problems on an ongoing changing basis until they finally succumb to the ravages of the AIDS virus.

It is clear that Maine also needs designated AIDS Centers which include comprehensive dental care. The NY experience shows that the multidisciplinary team approach with a continuum of care model has merit. Recently the Maine Medical Center has started an AIDS Center. This start has been well received by AIDS patients. Also, the Maine Medical Association has voted to help establish AIDS centers. I believe that ht e Maine Dental Association should work for the establishment of comprehensive dental facilities in multidisciplinary AIDS centers.

I have included some rather extensiv einformation form the NYS AIDS Institute Bureau of HIV Healthcare for your consideration.

The Delaware Dental Association has established a hospital based AIDS dental clinic in cooperation with the State of Delaware. I have talked to Robert Rosen, D.M.D., the president of the Delaware Dental Association. HE was very helpful and felt that dentists have a right to feel that their private offices are not a proper environment for HIV/AIDS patients. I have included the tedt of his speech given at the dedication of the Bissell hospital Dental clinic for your information.

There is also an AIDS Dental facility in Houston, Texas.

The Maine Dental Association stands poised to start a good thing for the citizens of Maine. We can help provide the best possible dental care for HIV/AIDS patients while at the same time providing the maximum protection to the uninfected citizens of Maine.

(Depo. Testimony of Don Craven, M.D. / July 21, 1995)

[13] Q: Do you believe it would be acceptable to [14] compel Dr. Bragdon to treat HIV patients in his [15] office if there was a substantial likelihood of one [16] transmission of HIV to Dr. Bragdon or his staff [17] over a 20-year period?

[18] MR. KLEIN:Object to the form.

[19] A: Well, maybe you could break the question [20] down into some different parts. I think it's a [21] complex question, so there are several issues [22] there. I can't sort of give you a yes or no answer [23] to all the things in the sentence. Maybe if you [24) could break it down into different parts I could

[1] give you a more accurate answer.
[2] Q: I take it you do think it's acceptable to [3] compel Dr. Bragdon to treat HIV-positive patients?
[4] MR. KLEIN:Objection to the form.
[5] Q: I thought this was the basis of the
[6] case. Maybe I'm wrong.
[7] MR. KLEIN:You're asking him for an [8] ultimate legal -
[9] Q: What you do believe?
[10] A: I believe that Dr. Bragdon should provide [11] dental services to HIV-infected patients.
[12] Q: And my question to you is given that [13] assumption, given that desire, would you still [14] believe it if there was a substantial likelihood of [15] one single transmission of HIV to Dr. Bragdon or [16] his staff let's say over a 20-year period?
[17] A: I wouldn't wish anything like that on Dr. [18] Bragdon or his staff, but I think that would not [19] change my opinion in providing services.
[20] Q: That's all I am getting at. You feel [21] that's a risk they're required to take? [22] A: Life is a risk.
[23] Q: Would the same be true if we reduce the [24] time frame to 10 years?

[1] A: Yes.
[2] Q: Would it be true if we reduced it to one [3] year?
[4] MR. KLEIN: I object.
[5] A: I don't know what you're getting at. I [6] obviously would not wish anyone -
- there's [7] obviously a risk, and I think he should provide [8] services. I'm not saying when you provide services [9] you provide it risk free and nothing happens. So [10] the time frame makes no difference to me.

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(AGD IMPACT June 1997)

Treating needlestick in juries from HIV-positive patients
One dentist gets a crash course in protocol
by Beth Burmahl

While injecting an HIV-positive patient with a local anesthetic last December, a Tennessee practitioner felt a sharp stick penetrate his double-gloved hand as he pulled the syringe from the patient's mouth.

The two pairs of gloves he wore as a precautionary measure did little to repel the needle's pierce, and the next thing he knew, "Boom, I was stuck," he says.

His heart sank when he saw a tiny speck of blood on one of his fingers, and was naturally "scared to death." My brain began to flash multiple messages." he says, and without telling any one what happened, he mechanically changed needles and finished injecting the anesthetic. Immediately afterward, he made a frightened phone call to his physician to get the latest protocol for treating needle stick injuries-- some thing he hadn't done beforehand even though several of his patients are HIV-positive.

Unfortunately, his physician wasn't sure what the latest protocol was in the quickly-changing area of treatment, but he got the information from the Arkansas Department of Health, which follows U.S. Public Health Service recommendations. The health department ordered a full set of blood tests and told the dentist to start drug therapy immediately.

Within five hours of the needlestick, he was on a heavy-duty "cocktail"

3300 milligrams of drugs including ZDV (AZT), Epivir, and Crixivan, the same combination now being prescribed to patients in active AIDS treatment. Soon he would be feeling some of the same effects - nausea, fatigue, diarrhea. But the emotional upheaval was even worse. How long would he be on this "cocktail?" Could he go back to work? What were his chances of contracting the virus, and most importantly, when would he know whether he contracted HIV or not?

To his great relief, the prognosis was good. He would be on the medication for a month, and could return to work

right away if he felt good enough. He would know for certain whether he contracted the disease in six months, and was advised to practice abstinence or safe sex during that time. He was not at a high risk. This occurs during exposure to both larger volumes of blood (a deep injury with a large bore hollow needle that was in a patient's vein or artery _ especially those involving a needle which contains a quantity of the patient's blood) and blood containing a high titer of HIV (a patient with acute retroviral illness or end-stage AIDS), according to the health department.

Even though the Tennessee dentist's needlestick penetrated the skin, his physician said he was an "extremely low risk" for contracting the infection since the speck of blood came from his own finger, since the patient he was treating was HIV-positive but hadn't developed AIDS, and since he was using a 30-gauge needle, which has a smaller bore. Percutaneous exposure carries a higher risk than the two other areas of exposure: mucous membrane and the skin surface.

According to the health department, risk of infection following parenteral needlestick exposure to blood infected with HIV is less than 0.3 percent overall. The dentist breathed a sigh of relief, but didn't exhale quite yet. Even a slim possibility of infection was a heavy burden to bear considering the possible consequences if the infection did occur.

More blood tests were needed - one at two weeks, four weeks, three months and six months. The side effects of the drugs felt like "a light case of the flu," but the dentist felt well enough to return to work immediately, and go on with his life as best he could. He didn't tell his patients about the ordeal, but says he was "extremely careful, like I always am," when treating them. He tested negative at three months, and even though there's a slim chance he could still contract the virus, he believes he's now "out of the woods."

"I won't know officially for another three months, but I'm incredibly hopeful," he says. "I honestly didn't think this could happen to me. Like other dentists, I thought I could prevent it. We all need to know the protocol and be prepared."

Incidents like the one the Tennessee dentist experienced are happening less, mainly because needlestick injuries in general appear to be declining due to the widespread awareness about HIV infection and the number of

preventive devices that have been developed.
"Needlestick injuries are way down," says Joseph L. Konzelman, Jr., DDS, associate professor in the department of oral diagnosis and patient service, school of dentistry, Medical College of Georgia. Dr. Konzelman says that when he worked at Walter Reed Hospital in 1981, "of the 103 people in my clinic, we used to average two sticks a day. Sticks there now are very unusual because of all the precautions and new devices and techniques. We have less than six a year. And we have far less at the Medical College of Georgia."
Dentists should always follow the universal precautions prescribed by OSHA (as the Tennessee dentist does), and devise a plan for handling needle stick injuries, regardless of their frequency. Dentists should get the name and address of the local health department or an infectious disease specialist, and call the physician to discuss the latest protocol for needlestick injuries. They should also make sure they'll have access to the drugs they will need should an injury occur.
If a dentist experiences a serious needlestick injury from a patient whose HIV status is unknown, he or she should ask the patient to take a blood test, which they are within their rights to refuse, says Dr. Konzelman. But he says that would be extremely rare. In that type of case, the dentist should wait for the results of the blood test which can be expedited in a few hours, before beginning treatment. Treatment for a needlestick from a known HIV-positive patient should optimally begin within two hours, and preferably before four hours, according to the health department.
When AIDS first erupted on the scene, needlestick injuries were treated with the same medication AIDS patients were receiving at that time: AZT. These days, "many new drugs have been shown to be remarkably effective when used in combination (with AZT) against the HIV infection itself," according to Dr. Konzelman, who says those drugs or some combination of them are also being used to treat needlestick injuries from HIV-positive patients.
In June 1996, the U.S. Public Health Service published recommendations for chemoprophylaxis after occupational exposure to HIV-positive patients. The postexposure prophylaxis (PEP) recommendations are based on a known exposure to HIV-positive patients.

These recommendations don't address non-occupational (sexual) exposure. The recommendations are: 200 milligrams three times a day of ZDV (Retrovir); 150 milligrams twice a day of Epivir (Lamivudine), and 800 milligrams three times a day of Crixivan (Indinavir). The choice of combination depends on the type of exposure: source materials; availability of medications; and existing contraindications.
Cheryl Newman, associate professor of Infectious Diseases and Medicine at the Medical College of Georgia, says the individual physician determines the exact drug regimen, but that "most hospitals already have needlestick prophylactic programs in place, and they have been modifying them in concert with the new recommendations."
Although the worst side effect the Tennessee dentist experienced was "feeling cruddy," the blood tests were also done to gauge the development of a more serious side effect: liver damage. Potential adverse reactions for both ZDV (AZT) and Epivir listed by the health department include a notation that "dosage must be adjusted in case of renal failure."
But Dr. Newman says that while the medication may elevate a chemical in the blood that comes from the liver, there "is no significant danger" to the liver from short-term exposure to the drugs.
Regardless of the number of risks he was exposed to and the psychological trauma he and his family endured, the dentist says he emerged from the situation wiser, and possibly a little less frightened.
But he's no more apprehensive about treating HIV-positive patients than he was before the experience, saying, "they have the same right as anyone else to get dental care."

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Patient Rights, Provider Rights: BALANCING THE CONFLICT

(First in a two part series)

BY PETER M. SFIKAS, J.D.

A federal appeals court decision in an HIV discrimination case raises tough questions about the rights of providers vs. the rights of patients.

An HIV-infected person with no obvious symptoms of AIDS comes to your office for treatment. You want this person to receive proper care, but you have concerns about your safety, the safety of your staff.

You wonder to yourself: can the government really force me to put aside my safety concerns and treat this person? How can this patient have rights as being "disabled" or "handicapped" when he or she is asymptomatic and not obviously limited by his or her HIV status? Even if the patient has rights, don't I have rights, too? And what about my professional judgment? Shouldn't I be allowed to decide whether it's safe for me to treat this patient or how best to do so?

Such questions were raised in the 1st Circuit Court of Appeals' decision on Abbott vs. Bragdon. In March, the appeals court affirmed a summary judgment that Maine dentist Randon Bragdon had violated the Americans with Disabilities Act when he refused to treat an HIV-infected patient in his private dental office. The court's opinion reads as a virtual case study on the delicate legal balance between provider and patient rights.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

Recommended Infection-Control Practices for Dentistry, 1993

Summary

This document updates previously published CDC recommendations for infection-control practices in dentistry to reflect new data, materials, technology, and equipment. When implemented, these recommendations should reduce the risk of disease transmission in the dental environment, from patient to dental health-care worker (DHCW), from DHCW to patient, and from patient to patient. Based on principles of infection control, the document delineates specific recommendations related to vaccination of DHCWs; protective attire and barrier techniques; handwashing and care of hands; the use and care of sharp instruments and needles; sterilization or disinfection of instruments; cleaning and disinfection of the dental unit and environmental surfaces; disinfection and the dental laboratory; use and care of handpieces, antiretraction valves, and other intraoral dental devices attached to air and water lines of dental units; single-use disposable instruments; the handling of biopsy specimens; use of extracted teeth in dental educational settings; disposal of waste materials; and implementation of recommendations.

INTRODUCTION

This document updates previously published CDC recommendations for infection-control practices for dentistry (1-3) and offers guidance for reducing the risks of disease transmission among dental health-care workers (DHCWs) and their patients. Although the principles of infection control remain unchanged, new technologies, materials, equipment, and data require continuous evaluation of current infection-control practices. The unique nature of most dental procedures, instrumentation, and patient-care settings also may require specific strategies directed to the prevention of transmission of pathogens among DHCWs and their patients. Recommended infection-control practices are applicable to all settings in which dental treatment is provided. These recommended practices should be observed in addition to the practices and procedures for worker protection required by the Occupational Safety and Health Administration (OSHA) final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030), which was published in the Federal Register on December 6, 1991 (4).

Dental patients and DHCWs may be exposed to a variety of microorganisms via blood or oral or respiratory secretions. These microorganisms may include cytomegalovirus, hepatitis B virus (HBV), hepatitis C virus (HCV), herpes simplex virus types 1 and 2, human immunodeficiency virus (HIV), Mycobacterium tuberculosis, staphylococci, streptococci, and other viruses and bacteria -- specifically, those that infect the upper respiratory tract. Infections may be transmitted in

the dental operatory through several routes, including direct contact with blood, oral fluids, or other secretions; indirect contact with contaminated instruments, operatory equipment, or environmental surfaces; or contact with airborne contaminants present in either droplet spatter or aerosols of oral and respiratory fluids. Infection via any of these routes requires that all three of the following conditions be present (commonly referred to as "the chain of infection"): a susceptible host; a pathogen with sufficient infectivity and numbers to cause infection; and a portal through which the pathogen may enter the host. Effective infection-control strategies are intended to break one or more of these "links" in the chain, thereby preventing infection.

A set of infection-control strategies common to all health-care delivery settings should reduce the risk of transmission of infectious diseases caused by bloodborne pathogens such as HBV and HIV (2,5-10). Because all infected patients cannot be identified by medical history, physical examination, or laboratory tests, CDC recommends that blood and body fluid precautions be used consistently for all patients (2,5). This extension of blood and body fluid precautions, referred to as "universal precautions," must be observed routinely in the care of all dental patients (2). In addition, specific actions have been recommended to reduce the risk of tuberculosis transmission in dental and other ambulatory health-care facilities (11).

CONFIRMED TRANSMISSION OF HBV AND HIV IN DENTISTRY

Although the possibility of transmission of bloodborne infections from DHCWs to patients is considered to be small (12- 15), precise risks have not been quantified in the dental setting by carefully designed epidemiologic studies. Reports published from 1970 through 1987 indicate nine clusters in which patients were infected with HBV associated with treatment by an infected DHCW (16-25). In addition, transmission of HIV to six patients of a dentist with acquired immunodeficiency syndrome has been reported (26,27). Transmission of HBV from dentists to patients has not been reported since 1987, possibly reflecting such factors as incomplete ascertainment and reporting, increased adherence to universal precautions -- including routine glove use by dentists -- and increased levels of immunity due to use of hepatitis B vaccine. However, isolated sporadic cases of infection are more difficult to link with a health-care worker than are outbreaks involving multiple patients. For both HBV and HIV, the precise event or events resulting in transmission of infection in the dental setting have not been determined; epidemiologic and laboratory data indicate that these infections probably were transmitted from the DHCWs to patients, rather than from one patient to another (26,28). Patient-to-patient transmission of bloodborne pathogens has been reported, however, in several medical settings (29-31).

VACCINES FOR DENTAL HEALTH-CARE WORKERS

Although HBV infection is uncommon among adults in the United States (1%-2%), serologic surveys have indicated that 10%-30% of health-care or dental workers show evidence of past or present HBV infection (6,32). The OSHA bloodborne pathogens final rule requires that employers make hepatitis B vaccinations available without cost to their employees who may be exposed to blood or other infectious materials (4). In addition, CDC recommends that all workers, including DHCWs, who might be exposed to blood or blood-contaminated substances in an occupational setting be vaccinated for HBV (6-8). DHCWs also are at risk for exposure to and possible transmission of other vaccine-preventable diseases (33); accordingly, vaccination against influenza, measles, mumps, rubella, and tetanus may be appropriate for DHCWs.

PROTECTIVE ATTIRE AND BARRIER TECHNIQUES

For protection of personnel and patients in dental-care settings, medical gloves (latex or vinyl) always must be worn by DHCWs when there is potential for contacting blood, blood-contaminated saliva, or mucous membranes (1,2,4-6). Nonsterile gloves are appropriate for examinations and other nonsurgical procedures (5); sterile gloves should be used for surgical procedures. Before treatment of each patient, DHCWs should wash their hands and put on new gloves; after treatment of

each patient or before leaving the dental operatory, DHCWs should remove and discard gloves, then wash their hands. DHCWs always should wash their hands and reglove between patients. Surgical or examination gloves should not be washed before use; nor should they be washed, disinfected, or sterilized for reuse. Washing of gloves may cause "wicking" (penetration of liquids through undetected holes in the gloves) and is not recommended (5). Deterioration of gloves may be caused by disinfecting agents, oils, certain oil-based lotions, and heat treatments, such as autoclaving.

Chin-length plastic face shields or surgical masks and protective eyewear should be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry (2,5,6,34,35). When a mask is used, it should be changed between patients or during patient treatment if it becomes wet or moist. Face shields or protective eyewear should be washed with an appropriate cleaning agent and, when visibly soiled, disinfected between patients.

Protective clothing such as reusable or disposable gowns, laboratory coats, or uniforms should be worn when clothing is likely to be soiled with blood or other body fluids (2,5,6). Reusable protective clothing should be washed, using a normal laundry cycle, according to the instructions of detergent and machine manufacturers. Protective clothing should be changed at least daily or as soon as it becomes visibly soiled (9). Protective garments and devices (including gloves, masks, and eye and face protection) should be removed before personnel exit areas of the dental office used for laboratory or patient-care activities.

Impervious-backed paper, aluminum foil, or plastic covers should be used to protect items and surfaces (e.g., light handles or x-ray unit heads) that may become contaminated by blood or saliva during use and that are difficult or impossible to clean and disinfect. Between patients, the coverings should be removed (while DHCWs are gloved), discarded, and replaced (after ungloving and washing of hands) with clean material.

Appropriate use of rubber dams, high-velocity air evacuation, and proper patient positioning should minimize the formation of droplets, spatter, and aerosols during patient treatment. In addition, splash shields should be used in the dental laboratory.

HANDWASHING AND CARE OF HANDS

DHCWs should wash their hands before and after treating each patient (i.e., before glove placement and after glove removal) and after barehanded touching of inanimate objects likely to be contaminated by blood, saliva, or respiratory secretions (2,5,6,9). Hands should be washed after removal of gloves because gloves may become perforated during use, and DHCWs' hands may become contaminated through contact with patient material. Soap and water will remove transient microorganisms acquired directly or indirectly from patient contact (9); therefore, for many routine dental procedures, such as examinations and nonsurgical techniques, handwashing with plain soap is adequate. For surgical procedures, an antimicrobial surgical handscrub should be used (10).

When gloves are torn, cut, or punctured, they should be

removed as soon as patient safety permits. DHCWs then should wash their hands thoroughly and reglove to complete the dental procedure. DHCWs who have exudative lesions or weeping dermatitis, particularly on the hands, should refrain from all direct patient care and from handling dental patient-care equipment until the condition resolves (12). Guidelines addressing management of occupational exposures to blood and other fluids to which universal precautions apply have been published previously (6-8,36).

USE AND CARE OF SHARP INSTRUMENTS AND NEEDLES

Sharp items (e.g., needles, scalpel blades, wires) contaminated with patient blood and saliva should be considered as potentially infective and handled with care to prevent injuries (2,5,6).

Used needles should never be recapped or otherwise manipulated utilizing both hands, or any other technique that involves directing the point of a needle toward any part of the body (2,5,6). Either a one-handed "scoop" technique or a mechanical device designed for holding the needle sheath should be employed. Used disposable syringes and needles, scalpel blades, and other sharp items should be placed in appropriate puncture-resistant containers located as close as is practical to the area in which the items were used (2,5,6). Bending or breaking of needles before disposal requires unnecessary manipulation and thus is not recommended.

Before attempting to remove needles from nondisposable aspirating syringes, DHCWs should recap them to

prevent injuries. Either of the two acceptable techniques may be used. For procedures involving multiple injections with a single needle, the unsheathed needle should be placed in a location where it will not become contaminated or contribute to unintentional needlesticks between injections. If the decision is made to recap a needle between injections, a one-handed "scoop" technique or a mechanical device designed to hold the needle sheath is recommended.

STERILIZATION OR DISINFECTION OF INSTRUMENTS

Indications for Sterilization or Disinfection of Dental Instruments

As with other medical and surgical instruments, dental instruments are classified into three categories -- critical, semicritical, or noncritical -- depending on their risk of transmitting infection and the need to sterilize them between uses (9,37-40). Each dental practice should classify all instruments as follows:

•Critical. Surgical and other instruments used to penetrate soft tissue or bone are classified as critical and should be sterilized after each use. These devices include forceps, scalpels, bone chisels, scalers, and burs.
•Semicritical. Instruments such as mirrors and amalgam condensers that do not penetrate soft tissues or bone but contact oral tissues are classified as semicritical. These devices should be sterilized after each use. If, however, sterilization is not feasible because the instrument will be

damaged by heat, the instrument should receive, at a minimum, high-level disinfection. •Noncritical. Instruments or medical devices such as external components of x-ray heads that come into contact only with intact skin are classified as noncritical. Because these noncritical surfaces have a relatively low risk of transmitting infection, they may be reprocessed between patients with intermediate-level or low-level disinfection (see Cleaning and Disinfection of Dental Unit and Environmental Surfaces) or detergent and water washing, depending on the nature of the surface and the degree and nature of the contamination (9,38).

Methods of Sterilization or Disinfection of Dental Instruments

Before sterilization or high-level disinfection, instruments should be cleaned thoroughly to remove debris. Persons involved in cleaning and reprocessing instruments should wear heavy-duty (reusable utility) gloves to lessen the risk of hand injuries. Placing instruments into a container of water or disinfectant/detergent as soon as possible after use will prevent drying of patient material and make cleaning easier and more efficient. Cleaning may be accomplished by thorough scrubbing with soap and water or a detergent solution, or with a mechanical device (e.g., an ultrasonic cleaner). The use of covered ultrasonic cleaners, when possible, is recommended to increase efficiency of cleaning and to reduce handling of sharp instruments.

All critical and semicritical dental instruments that are heat stable should be sterilized routinely between uses by

steam under pressure (autoclaving), dry heat, or chemical vapor, following the instructions of the manufacturers of the instruments and the sterilizers. Critical and semicritical instruments that will not be used immediately should be packaged before sterilization.

Proper functioning of sterilization cycles should be verified by the periodic use (at least weekly) of biologic indicators (i.e., spore tests) (3,9). Heat-sensitive chemical indicators (e.g., those that change color after exposure to heat) alone do not ensure adequacy of a sterilization cycle but may be used on the outside of each pack to identify packs that have been processed through the heating cycle. A simple and inexpensive method to confirm heat penetration to all instruments during each cycle is the use of a chemical indicator inside and in the center of either a load of unwrapped instruments or in each multiple instrument pack (41); this procedure is recommended for use in all dental practices. Instructions provided by the manufacturers of medical/dental instruments and sterilization devices should be followed closely.

In all dental and other health-care settings, indications for the use of liquid chemical germicides to sterilize instruments (i.e., "cold sterilization") are limited. For heat-sensitive instruments, this procedure may require up to 10 hours of exposure to a liquid chemical agent registered with the U.S. Environmental Protection Agency (EPA) as a "sterilant/disinfectant." This sterilization process should be followed by aseptic rinsing with sterile water, drying, and, if the instrument is not used immediately, placement in a sterile container.

EPA-registered "sterilant/disinfectant" chemicals are used to attain high-level disinfection of heat-sensitive

semicritical medical and dental instruments. The product manufacturers' directions regarding appropriate concentration and exposure time should be followed closely. The EPA classification of the liquid chemical agent (i.e., "sterilant/disinfectant") will be shown on the chemical label. Liquid chemical agents that are less potent than the "sterilant/disinfectant" category are not appropriate for reprocessing critical or semicritical dental instruments.

CLEANING AND DISINFECTION OF DENTAL UNIT AND ENVIRONMENTAL SURFACES

After treatment of each patient and at the completion of daily work activities, countertops and dental unit surfaces that may have become contaminated with patient material should be cleaned with disposable toweling, using an appropriate cleaning agent and water as necessary. Surfaces then should be disinfected with a suitable chemical germicide.

A chemical germicide registered with the EPA as a "hospital disinfectant" and labeled for "tuberculocidal" (i.e., mycobactericidal) activity is recommended for disinfecting surfaces that have been soiled with patient material. These intermediate-level disinfectants include phenolics, iodophors, and chlorine-containing compounds. Because mycobacteria are among the most resistant groups of microorganisms, germicides effective against mycobacteria should be effective against many other bacterial and viral pathogens (9,38-40,42). A fresh solution of sodium hypochlorite (household bleach) prepared daily is an inexpensive and effective intermediate-level germicide. Concentrations ranging

from 500 to 800 ppm of chlorine (a 1:100 dilution of bleach and tap water or 1/4 cup of bleach to 1 gallon of water) are effective on environmental surfaces that have been cleaned of visible contamination. Caution should be exercised, since chlorine solutions are corrosive to metals, especially aluminum.

Low-level disinfectants -- EPA-registered "hospital disinfectants" that are not labeled for "tuberculocidal" aetivity (e.g., quaternary ammonium compounds) -- are appropriate for general housekeeping purposes such as cleaning floors, walls, and other housekeeping surfaces. Intermediate- and low-level disinfectants are not recommended for reprocessing critical or semicritical dental instruments.

DISINFECTION AND THE DENTAL LABORATORY

Laboratory materials and other items that have been used in the mouth (e.g., impressions, bite registrations, fixed and removable prostheses, orthodontic appliances) should be cleaned and disinfected before being manipulated in the laboratory, whether an on-site or remote location (43). These items also should be cleaned and disinfected after being manipulated in the dental laboratory and before placement in the patient's mouth (2). Because of the increasing variety of dental materials used intraorally, DHCWs are advised to consult with manufacturers regarding the stability of specific materials relative to disinfection procedures. A chemical germicide having at least an intermediate level of activity (i.e., "tuberculocidal hospital disinfectant") is appropriate for such disinfection. Communication between dental office and dental laboratory personnel regarding the handling and

decontamination of supplies and materials is important.

USE AND CARE OF HANDPIECES, ANTIRETRACTION VALVES, AND OTHER INTRAORAL DENTAL DEVICES ATTACHED TO AIR AND WATER LINES OF DENTAL UNITS

Routine between-patient use of a heating process capable of sterilization (i.e., steam under pressure {autoclaving}, dry heat, or heat/chemical vapor) is recommended for all high-speed dental handpieces, low-speed handpiece components used intraorally, and reusable prophylaxis angles. Manufacturers' instructions for cleaning, lubrication, and sterilization procedures should be followed closely to ensure both the effectiveness of the sterilization process and the longevity of these instruments. According to manufacturers, virtually all high-speed and low-speed handpieces in production today are heat tolerant, and most heat-sensitive models manufactured earlier can be retrofitted with heat-stable components.

Internal surfaces of high-speed handpieces, low-speed handpiece components, and prophylaxis angles may become contaminated with patient material during use. This retained patient material then may be expelled intraorally during subsequent uses (44-46). Restricted physical access -- particularly to internal surfaces of these instruments -- limits cleaning and disinfection or sterilization with liquid chemical germicides. Surface disinfection by wiping or soaking in liquid chemical germicides is not an acceptable method for reprocessing high-speed handpieces, low-speed handpiece components used intraorally, or reusable prophylaxis angles.

Because retraction valves in dental unit water lines may cause aspiration of patient material back into the handpiece and water lines, antiretraction valves (one-way flow check valves) should be installed to prevent fluid aspiration and to reduce the risk of transfer of potentially infective material (47). Routine maintenance of antiretraction valves is necessary to ensure effectiveness; the dental unit manufacturer should be consulted to establish an appropriate maintenance routine.

High-speed handpieces should be run to discharge water and air for a minimum of 20-30 seconds after use on each patient. This procedure is intended to aid in physically flushing out patient material that may have entered the turbine and air or water lines (46). Use of an enclosed container or high-velocity evacuation should be considered to minimize the spread of spray, spatter, and aerosols generated during discharge procedures. Additionally, there is evidence that overnight or weekend microbial accumulation in water lines can be reduced substantially by removing the handpiece and allowing water lines to run and to discharge water for several minutes at the beginning of each clinic day (48). Sterile saline or sterile water should be used as a coolant/irrigator when surgical procedures involving the cutting of bone are performed.

Other reusable intraoral instruments attached to, but removable from, the dental unit air or water lines -- such as ultrasonic scaler tips and component parts and air/water syringe tips -- should be cleaned and sterilized after treatment of each patient in the same manner as handpieces, which was described previously. Manufacturers' directions for reprocessing should be

followed to ensure effectiveness of the process as well as longevity of the instruments.

Some dental instruments have components that are heat sensitive or are permanently attached to dental unit water lines. Some items may not enter the patient's oral cavity, but are likely to become contaminated with oral fluids during treatment procedures, including, for example, handles or dental unit attachments of saliva ejectors, high-speed air evacuators, and air/water syringes. These components should be covered with impervious barriers that are changed after each use or, if the surface permits, carefully cleaned and then treated with a chemical germicide having at least an intermediate level of activity. As with high-speed dental handpieces, water lines to all instruments should be flushed thoroughly after the treatment of each patient; flushing at the beginning of each clinic day also is recommended.

SINGLE-USE DISPOSABLE INSTRUMENTS

Single-use disposable instruments (e.g., prophylaxis angles; prophylaxis cups and brushes; tips for high-speed air evacuators, saliva ejectors, and air/water syringes) should be used for one patient only and discarded appropriately. These items are neither designed nor intended to be cleaned, disinfected, or sterilized for reuse.

HANDLING OF BIOPSY SPECIMENS

In general, each biopsy specimen should be put in a sturdy container with a secure lid to prevent leaking during transport. Care should be taken when collecting

specimens to avoid contamination of the outside of the container. If the outside of the container is visibly contaminated, it should be cleaned and disinfected or placed in an impervious bag (49).

USE OF EXTRACTED TEETH IN DENTAL EDUCATIONAL SETTINGS

Extracted teeth used for the education of DHCWs should be considered infective and classified as clinical specimens because they contain blood. All persons who collect, transport, or manipulate extracted teeth should handle them with the same precautions as a specimen for biopsy (2). Universal precautions should be adhered to whenever extracted teeth are handled; because preclinical educational exercises simulate clinical experiences, students enrolled in dental educational programs should adhere to universal precautions in both preclinical and clinical settings. In addition, all persons who handle extracted teeth in dental educational settings should receive hepatitis B vaccine (6-8).

Before extracted teeth are manipulated in dental educational exercises, the teeth first should be cleaned of adherent patient material by scrubbing with detergent and water or by using an ultrasonic cleaner. Teeth should then be stored, immersed in a fresh solution of sodium hypochlorite (household bleach diluted 1:10 with tap water) or any liquid chemical germicide suitable for clinical specimen fixation (50).

Persons handling extracted teeth should wear gloves. Gloves should be disposed of properly and hands washed after completion of work activities. Additional personal

protective equipment (e.g., face shield or surgical mask and protective eyewear) should be worn if mucous membrane contact with debris or spatter is anticipated when the specimen is handled, cleaned, or manipulated. Work surfaces and equipment should be cleaned and decontaminated with an appropriate liquid chemical germicide after completion of work activities (37,38,40,51).

The handling of extracted teeth used in dental educational settings differs from giving patients their own extracted teeth. Several states allow patients to keep such teeth, because these teeth are not considered to be regulated (pathologic) waste (52) or because the removed body part (tooth) becomes the property of the patient and does not enter the waste system (53).

DISPOSAL OF WASTE MATERIALS

Blood, suctioned fluids, or other liquid waste may be poured carefully into a drain connected to a sanitary sewer system. Disposable needles, scalpels, or other sharp items should be placed intact into puncture-resistant containers before disposal. Solid waste contaminated with blood or other body fluids should be placed in sealed, sturdy impervious bags to prevent leakage of the contained items. All contained solid waste should then be disposed of according to requirements established by local, state, or federal environmental regulatory agencies and published recommendations (9,49).

IMPLEMENTATION OF RECOMMENDED INFECTION-CONTROL PRACTICES FOR DENTIS

Emphasis should be placed on consistent adherence to

recommended infection-control strategies, including the use of protective barriers and appropriate methods of sterilizing or disinfecting instruments and environmental surfaces. Each dental facility should develop a written protocol for instrument reprocessing, operatory cleanup, and management of injuries (3). Training of all DHCWs in proper infection-control practices should begin in professional and vocational schools and be updated with continuing education.

ADDITIONAL NEEDS IN DENTISTRY

Additional information is needed for accurate assessment of factors that may increase the risk for transmission of bloodborne pathogens and other infectious agents in a dental setting. Studies should address the nature, frequency, and circumstances of occupational exposures. Such information may lead to the development and evaluation of improved designs for dental instruments, equipment, and personal protective devices. In addition, more efficient reprocessing techniques should be considered in the design of future dental instruments and equipment. Efforts to protect both patients and DHCWs should include improved surveillance, risk assessment, evaluation of measures to prevent exposure, and studies of postexposure prophylaxis. Such efforts may lead to development of safer and more effective medical devices, work practices, and personal protective equipment that are acceptable to DHCWs, are practical and economical, and do not adversely affect patient care (54,55).

ABA JOURNAL / July 1997

COVER STORY / HIV AND THE LAW
Filling a Need

BY JOHN GIBEAUT

Lawyers are drilling home the point that dentists who won't treat HIV patients may be practicing the most pervasive discrimination of all

* * *

But people who have suffered discrimination by health care providers because of their HIV status received a boost in March from a panel of the 1st U.S. Circuit Court of Appeals based in Boston. The 1st Circuit became the first federal appeals court to hold that people with the human immunodeficiency virus, or HIV, are protected by the Americans with Disabilities Act, even if they show no signs of illness.

On March 5, the panel unanimously backed a trial court's grant of summary judgment for an HIV-positive woman who displayed no symptoms of AIDS but was refused treatment by a dentist. Abbott v. Bragdon, 107 F.3d 934.

* * *

The ADA, though perhaps underused in many areas, appears to be developing into the legal weapon of choice for people who claim discrimination due to HIV status. Even though private plaintiffs cannot recover monetary

damages un-der the ada, the Abbott holding raises at least a symbolic federal civil rights umbrella over people with HIV.

The 7-year-old ada forbids discrimination against disabled people in employment, government services and public accommodations. Private plaintiffs can obtain injunctions to force defendants to accommodate them, and if the government files the suit, it can ask for damages for victims, as well as fines starting at $50,000 for the first violation.

Besides targeting health care discrimination, plaintiffs' advocates have painted bullseyes on defendants who deny employment and insurance coverage. For example, HIV infection was afactor in only 1.8 percent of the charges filed with the Equal Employment Opportunity Commission during the first five years of the ADA but accounted for about one-third of the 89 lawsuits filed by the agency. See "Opening Doors," March 1996 ABA Journal, page 66.

Among recent HIV-related legal actions under the act are:

• A March 27 lawsuit filed against the Chicago public school system--the nation's third largest --by a man who says he was denied a teaching job because he is HIV-positive. Among other allegations, he accused the school system of violating an executive order by Mayor Richard M. Daley that forbids city agencies from forcing job applicants to reveal their HIV status. Doe v. Board of Education of Chicago, N.D. Ill., E. Div., No. 97-C-2167.

• A decision last year in a case in which a Beaumont, Texas, clothing store switched to a health care plan that excluded an employee who later died of AIDS. The trial court held that both the employer and the insurance carrier faced potential liability under the ada. The court denied summary judgment for the plaintiff,

however, and gave the employer an opportunity to prove that it would be an undue hardship to provide equal insurance to the infected employee. Anderson v. Gus Mayer Boston Store of Delaware, Inc., 924 F. Supp. 763 (E.D. Texas 1996).

• A 1994 case of an HIV-positive automotive parts distributor whose insurance, bought through a trade association, capped benefits for AIDS-related illnesses. The 1st Circuit held that the association and administering trust for the health plan may be considered employers and thus possibly liable under the ada. The court also held that public accommodations provisions of the act could apply to sales of services and not just to physical structures. Carparts Distribution Center, Inc. v. Automotive Wholesalers Ass'n of New England, Inc., 37 F.3d 12.

Defining 'Disabled'

Indeed, the question of whether HIV-positive people are disabled within the meaning of the ada is not likely to disappear anytime soon as new treatments allow them to live longer without developing full-blown AIDS.

In fact, the federal Centers for Disease Control and Prevention reported earlier this year that the number of deaths from AIDS declined by 13 percent from 1995 to '96, the first decrease since the epidemic began in the early 1980s. The CDC attributed the drop partly to improved treatment.

Yet the debate is sure to intensify as the disease shatters its stereotyped victim pattern--gay men and intravenous drug users--and affects a wider spectrum of the population.

"That is an issue that is growing in importance," says Bennett H. Klein, AIDS Law Project director for Gay & Lesbian Advocates & Defenders of Boston. "HIV

impairs people in ways much the same as blindness and deafness do."

* * *

Seeing Red

As many as 900,000 Americans have the virus that causes AIDS, an incurable disease that destroys the body's immune system. HIV is chiefly transmitted from person to person through an exchange of body fluids, usually during sex, or through intravenous drug use or blood transfusions. Some dentists claim they run a higher risk of contracting the virus because even routine dental care typically causes patients to bleed.

* * *

Abbott went to court, suing the dentist under both the ada and the Maine Human Rights Act. To prevail, she had to show that her condition "substantially limits" a major life activity.

While she had no AIDS symptoms, Abbott maintained that she could not have children because of the danger of passing the virus to them. Although courts have split on the issue in different contexts, the 1st Circuit agreed that reproduction was a major life activity impaired by Abbott's condition.

The panel rejected Bragdon's contention that the decision to have children is merely a lifestyle choice, not a major life activity.

"That emaciated argument lacks force," Judge Bruce M. Selya wrote for the court. "To treat reproduction as a lifestyle choice, and no more, is merely an exercise in semantics. Most acts that human beings perform--or refrain from performing--have elements of volition. Speaking is undoubtedly a major life activity, but there are those (say, monks who have taken vows of

silence) who choose to eschew it."

The court also shunned Bragdon's statutory defense allowed by the ada that Abbott's HIV status posed a "direct threat to the health or safety of others." The judges noted that public health authorities--including the dental association--agree that the risk of HIV transmission from patient to health care provider is minuscule.

* * *

Also unresolved was the ada's protection for someone incapable of having children for some reason other than HIV infection.

* * *

In view of Abbott, however, Burris of Temple University says sexual orientation should not be a factor in a court's evaluation of whether reproduction is a major life activity. "It doesn't seem to be the intention to reproduce; it's the ability to reproduce," he says.

Looking Back

As the likelihood increases that the Supreme Court will take an HIV case for review, a precursor to any decision may lie in its 10-year-old holding that a Florida schoolteacher fired for having tuberculosis was covered by the Rehabilitation Act. That statute is similar to the ada and forbids federally funded programs from discriminating against people with disabilities. School Board of Nassau County, Fla. v. Arline, 480 U.S. 273 (1987).

"Congress acknowledged that society's accumulated myths and fears about disability and disease

are as handicapping as are the phys-ical limitations that flow from the actual impairment," Justice William J. Brennan Jr. wrote for the seven-member majority. "Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness."

The Abbott court also took a cue from Arline that public health authorities know best, and deferred to the judgments of the dental association and the federal Centers for Disease Control and Prevention that routine care of HIV patients in dental offices is safe when appropriate precautions are taken.

Indeed, advocates for these patients estimate that more than 2 billion dental procedures have tak-en place since the outbreak of AIDS in the early 1980s--without a single documented case of transmission from a patient to a dentist.

"Tellingly, no public health authority has suggested that it is unsafe to provide routine dental care to HIV-positive patients in a private office environment," the 1st Circuit panel stated.

Dentists, Physicians Look at HIV Patients With Different Eyes

Dentists certainly are not the only health care providers who have been sued for refusing to treat people who are HIV-positive. Physicians, hospitals and other providers also have been hit with lawsuits.

Yet surveys of patients and of dentists themselves suggest that prejudice against HIV patients may be more common among dentists.

To get a general idea of how widespread such discrimination by dentists might be, Temple University law Professor Scott Burris surveyed 272 people with HIV in the Philadelphia area in 1995. He found that nearly one

in five reported experiencing discrimination during the previous five years.

Burris says the demographics of his survey sample are comparable to those of the 2,782 HIV-positive population reported in the Philadelphia metropolitan statistical area in 1994. That means more than 500 people in Philadelphia alone may have experienced discrimination by dentists.

"If my results can be extrapolated across the country, there would be thousands and thousands of cases,"Burris says.

Another survey published in 1992 by the American Journal of Public Health was conducted among 1,533 gay and bisexual men in Los Angeles and Baltimore. Of this sample, significantly more reported that dentists refused to treat them because the providers knew or suspected they had HIV or AIDS.

Of the 96 men who actually had AIDS, 16 percent reported refusals by dentists, and 5 percent reported refusals by physicians. Of the 585 HIV-positive men, 4 percent said they were turned away by dentists, while 3 percent reported refusals by physicians. The remaining 852 men were HIV-negative, with 1 percent reporting refusals by dentists and another 1 percent reporting physician refusals, indicating that sexual orientation was not a significant factor.

In a nationwide survey of 671 dentists published in 1995 in the Journal of the American Dental Association, 67 percent reported that they were willing to treat HIV-positive patients, and 84 percent believed it was their right to decide whether to accept those patients. The 67 percent of dentists willing to treat HIV patients in the 1993 survey year represented an increase from 21 percent in a 1986 survey.

For his part, Dr. Randon Bragdon says his resolve

against treating people with contagious diseases became stronger after he contracted a form of dysentery from a patient. Bragdon is the Bangor, Maine, dentist whose refusal to treat an HIV patient in his office led to an appellate decision that brought HIV status under the protection of the Americans with Disabilities Act.

The dysentery he caught from a patient kept Bragdon from practicing for three weeks. "I was very sick, and I certainly didn't want anybody else to be," he says.

Reasons for Caution

While Burris and others suspect that physicians also discriminate significantly against HIV patients, they note several distinctions between dentistry and medicine that may account for the difference:

• Although the evidence is to the contrary, dentists may peceive greater risks of contracting HIV by coming into contact with a patient's blood. A typical dental examination is a more invasive procedure than a routine physical exam and often draws blood, even during routine cleaning. Some dentists also believe they are more at risk because they use high-speed drills and water hoses that can spray a mist of blood into the air and because they are more likely to get stuck with needles.

• Physicians, by virtue of their training, are accustomed to treating many deadly diseases, while dentists are not. "There are other diseases that are even more infectious and just as fatal as AIDS," says Dr. Yank D. Coble, an American Medical Association trustee from Jacksonville, Fla.

• Dentists may fear losing business when people learn they are treating HIV patients. In fact, 75 percent of the dentists in the dental association journal survey reported they were afraid to show a willingness to treat

HIV patients for fear of driving away other patients.

"I don't want to be known as the 'AIDS dentist,' " says a Boston dentist who treats HIV patients and requested anonymity. "I think there's a good chance that you'll lose patients if word gets out that you're treating people who are HIV-positive."

Perhaps most significant was a torrent of negative publicity that swamped the dental profession in the late 1980s after the public learned that Dr. David Acer, an infected Stuart, Fla., dentist, had passed on hiv to at least half a dozen of his patients. Acer died in 1990.

"We had, literally, for a time, people who were scared to death to go to a dentist's office," says Dr. Gary Rainwater, president of the American Dental Association. "There's probably still some hangover from that."

--John Gibeaut

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In Focus: Corporate Counsel

Employment Law Special

IS INFERTILITY AN ADA 'DISABILITY'?

IF REPRODUCTION IS DEEMED A MAJOR LIFE ACTIVITY, EMPLOYERS' INSURANCE COSTS MAY ESCALATE.

Gary D. Friedman and Joyce Phillips [FNa]
Special to the National Law Journal

THE 8TH U.S. Circuit Court of Appeals recently ruled in Krauel v. Iowa Methodist Medical Center [FN1] that the inability to conceive a child or reproduce is not an impairment of a "major life activity" under the Americans With Disabilities Act, or ADA. [FN2] The ruling sets the stage for a heated debate among the courts over whether infertility is a protected impairment under the ADA, and thus whether employers must pay for employees' infertility treatments and refrain from taking adverse action against workers who suffer from this impairment.

Infertility affects up to one in six couples in America. It

is estimated that more than S1 billion is spent annually by couplēs seeking to overcome infertility, [FN3] and this amount is likely to rise as infertility becomes a new area for workplace legal battles. More employers are being sued by workers seeking to invoke the protections of the federal anti-discrimination laws, particularly the ADA, to require coverage for infertility treatments and prohibit discrimination relating to those treatments. [FN4]

Until recently, employment decisions, such as whether to offer infertility benefits as part of a health care package, were strictly business judgments. However, 11 states-Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, New York, Rhode Island and Texas-now mandate either full or limited coverage of such treatments, although employers in states with self-funded plans are exempt.

The Employee Retirement Income Security Act, or ERISA, pre-empts all state laws relating to health plans except those that regulate insurance. Under ERISA, however, a self-funded plan is not deemed to be "insurance," so those plans are exempt even from state insurance regulations. [FN5] Although only 15 percent of companies with 10 to 499 employees self-fund, 91 percent of companies with 20,000 or more employees do so. [FN6]

Given the lack of a mandate to provide coverage for these treatments and the potentially high cost of doing so, it is no surprise that relatively few employers provide such coverage. Only 25 percent of traditional indemnity health plans and 37 percent of HMOs offer coverage for infertility treatments, and even fewer cover high-cost procedures, such as in-vitro fertilization. [FN7] Thus, employees now are starting to seek judicial intervention in a matter they previously handled on their own or informally with their employers.

Enacted in 1990, the ADA prohibits discrimination against disabled individuals on the basis of their disabilities. Title I, which governs private employment, "prohibits discrimination in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."

[FN8] The main purpose of Title I is to ensure that disabled persons are afforded equal opportunity in the workplace, including equal access to the "privileges" of employment, such as health benefits. [FN9]

The threshold question in determining whether employers must provide infertility treatment benefits is whether infertility is a "disability" under the ADA. The 8th and 5th circuits, in the recent cases of Krauel [FN1O] and Zatarian v. WDSU-Television Inc., [FN11] have concluded that infertility is not a disability under the ADA, but several decisions from the Northern District of Illinois have reached a contrary conclusion.

Infertility as a 'Disability'

The ADA defines "disability" as "a physical or mental impairment that substantially limits one or more of the major life activities." [FN12] Federal courts that have considered the issue appear to agree that infertility is an impairment under the ADA, but they vigorously disagree over whether the ability to reproduce, which is adversely affected by the impairment, is a major life activity.

The 8th Circuit's decision in Krauel is the most recent treatment of the issue. The plaintiff was a hospital employee covered by a self-funded health plan that excluded coverage for infertility treatments. Following a diagnosis of endometriosis, the plaintiff had laser surgery. After a year of unsuccessful attempts to conceive naturally, the plaintiff received artificial insemination, resulting in the birth of her child. Although her health plan covered the costs of her laser surgery, pregnancy and delivery, it did not cover the costly infertility treatment. She sued, challenging the denial of benefits under the ADA, the Pregnancy Discrimination Act and Title VII of the Civil Rights Act. The district court granted summary judgment for her employer.

The 8th Circuit affirmed, concluding that infertility is not a covered disability under the ADA, notwithstanding the Equal Employment Opportunity Commission's specific regulations defining a "physical or mental impairment" as including a disorder of the reproductive

system [FN13] and infertility as a covered physical impairment. [FN14] Central to the court's analysis was the conclusion that the ability to reproduce is not a major life activity, such as "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working," under the ADA. [FN15]

The court found that the plaintiff was able to do all these things, and that her infertility in no way prevented her from performing her job duties. It concluded that "to treat reproduction and caring for others as major life activities under the ADA would be inconsistent with the illustrative list of activities in the regulations, and a considerable stretch of federal law." [FN16]

In Zatarain, the 5th Circuit also considered the issue of whether infertility is a disability, and decided that it is not. The plaintiff, a reporter and anchor person for a Louisiana television station, requested and was granted reduced work hours from her three daily newscasts during the period of her infertility treatments. After the station chose not to renew her contract, she brought suit under the ADA and Title VII, alleging, among other things, that her infertility was a disability that impaired the major life functions of working and reproduction. The district court granted the station's summary judgment motion, and the 5th Circuit affirmed without opinion.

The lower court found unpersuasive the plaintiff's claim that her inability to work all three daily newscasts rendered her unable to perform her job, concluding that the "inability to perform a single particular job does not constitute a substantial limitation in the major life activity of working." [FN17] The court also rejected the plaintiff's argument that reproduction is a major life activity under the ADA, stating that a "person is required to walk, see, learn, speak, breathe, and work throughout the day, day in and day out [but] a person is not called upon to reproduce throughout the day, every day." [FN18] Thus, the court held that treating reproduction as a major life activity would be an expansion of the law it was unprepared to make. Other courts, however, have reached a contrary conclusion as to whether infertility is

a protected disability under the ADA. For example, in Pacourek v. Inland Steel Co., [FN19] the plaintiff's lengthy infertility treatments caused her to miss many workdays. Following her termination for excessive absenteeism, she brought an ADA action against her employer, alleging that she was fired because of her condition.

In denying the employer's motion to dismiss the ADA claim, the court held that the EEOC regulation defining "physical impairment" to include a disorder of the reproductive system would be meaningless if reproduction was not considered a major life activity, because reproduction is the most likely activity affected by a disorder of the reproductive system. It also noted that the 7th Circuit, in McWright v. Alexander, [FN2O] concluded that Rehabilitation Act regulations, which are virtually identical to the ADA regulations, "define the protected class of handicapped individuals to include any person with a physiological disorder affecting the reproductive system." [FN21]

More recently, the Pacourek court denied the employer's motion for summary judgment, concluding that "none of us, nor any living thing, would exist without reproduction. . . [T]o call working a major life activity, but to deny the same status to reproduction seems ludicrous." [FN22]

Relying on the Pacourek analysis, a Northern District of Illinois court, in Erickson v. Board of Governors, [FN23] also held that infertility is a protected disability under the ADA. The plaintiff, who was fired for excessive absenteeism that she claimed was attributable to her infertility treatments, brought an action under the ADA. In moving to dismiss the ADA claim, her employer argued that reproduction could not be a major life activity because: it required the participation of two individuals; it was a "very complex process," unlike such basic functions as walking, seeing, hearing, speaking and breathing; and an individual was not called upon to reproduce every day.

The Erickson court found these arguments unpersuasive. The court held that the EEOC list was full of activities that involved interacting with others, such as

talking and listening, and that although the EEOC examples such as thinking and talking are complex processes, the simplicity or complexity of an activity is not relevant to whether an activity is a major life activity. Finally, the court rejected the reasoning of Zatarain, concluding that it had ignored "the processes that occur continually in both the male and female reproductive systems in order to achieve conception." [FN24] Thus, it concluded that infertility is a physical impairment that substantially limits the major life activity of reproduction, and denied the motion to dismiss.

There appears to be additional support for the conclusion reached in Pacourek and Erickson that reproduction is a major life activity. First, both the ADA's legislative history and the EEOC's regulations list the reproductive system as a system that may be affected by an impairment. [FN25] Infertility is the most common and most easily imagined result of an impaired reproductive system. The Pacourek court concluded that the reproductive system would not have been listed if reproduction had not been deemed a major life activity. [FN26]

HIV Disability Case Law

Second, the legislative history indicates that the human immunodeficiency virus, or HIV, infection is a disability because, at least in part, it affects reproduction, not necessarily physiologically, but in practical terms, because the virus can be passed to the fetus and pregnancy can compromise the immune system. Being HIV-positive is, therefore, a substantial limitation to procreation and intimate sexual relationships. [FN27] This, too, has been accepted by several courts in holding that being HIV-positive constitutes a disability. [FN28]

For example, in Doe v. Kohn, Nast & Graf P.C., [FN29] an attorney who was terminated by his firm following disclosure that he was HIV-infected brought suit under the ADA and several state laws. Arguing that the plaintiff was not disabled under the ADA because AIDS did not affect his ability to work, the law firm contended:

"Not in any way to be facetious, but plaintiff is not being hired to practice procreation, or to be a professional blood donor, for example. He is being hired to practice law." The court rejected this argument, noting that Congress had chosen to use "major life activity" as the basis for ADA protection, instead of "work-life" or "major work activities," and held "that the language of the [ADA] does not preclude procreating as a major life activity." [FN3O]

In light of the legislative history, the EEOC regulations and decisions concerning HIV, there is a legitimate argument that, notwithstanding the 5th and 8th circuits' reasoning, infertility is a disability under the ADA. According to these authorities, reproduction is prime among the major life activities adversely affected by HIV infection. As the Pacourek court observed, reproduction is perhaps foremost among all life activities. If courts accept infertility as a disability, this will represent a substantial expansion of the federal anti-discrimination laws.

Determining whether infertility is a disability under the ADA may not be the end of the analysis regarding health plans. If the courts resolve that the ADA prohibits discrimination related to infertility, they will need to decide how far the ADA extends in regulating health plans. Judicial decisions that interpret coverage broadly could result in a significant increase in the cost of employer-provided health benefits.

Resolution of this issue is complicated by the fact that the ADA does not prohibit all distinctions in coverage that affect disabled individuals. For example, the ADA does not prohibit nondisability-based limits or exclusions on coverage, even those that disproportionately affect disabled employees. [FN31] The ADA also permits disability-based distinctions based on risk classification. [FN32] But neither exception applies if used as a subterfuge to evade the statute's provisions. [FN33]

This issue is clouded further by the dearth of legislative history on the subject. The EEOC, however, has issued an interim guidance on the provisions of this exception. [FN34] Although these guidelines do not have the same force, and courts are not required to give them the same

deference, as regulations, they are a good starting point in the analysis. The EEOC interpretation is likely the most expansive the courts would adopt. Thus, the guidelines provide a useful indicator of how courts will resolve this issue.

The interim guidance establishes a two-step framework for determining whether a distinction in a health care plan violates the ADA. First, it must be determined whether a distinction is disability-based. If it is, the EEOC still would allow the employer to provide coverage in accordance with accepted principles of risk assessment and/or risk classification, even if this limits coverage for disabled individuals.

Determining whether the distinction is disability-based is the first step because "distinctions that are not based on disability, and that are applied equally to all insured employees, do not discriminate on the basis of disability and so do not violate the ADA." [FN35] For example, a limit on eye exams affects employees with severely impaired vision and eye-related diseases, but it also affects employees who need glasses or contact lenses. The ADA allows for these limits "although such distinctions may have a greater impact on certain individuals with disabilities." [FN36]

The 8th Circuit discussed these guidance provisions in Krauel, even though it already had determined that reproduction was not a major life activity and, therefore, that infertility was not a disability. The court concluded that the exclusion of coverage for infertility treatments affected both the disabled and the nondisabled. The court used an example involving two employees: one infertile as a result of ovarian cancer, which is a disability, and the other infertile because of age, which is not a disability.

The Zatarain court also noted that infertility may be caused by stress, which would not likely be viewed as an impairment. Thus, the Krauel court concluded that a benefits plan that did not provide infertility treatments, regardless of the condition's cause, would not violate the ADA. If the 8th Circuit is correct that not all infertility is caused by an impairment, and thus is not a disability under the ADA, it would appear that even the EEOC

interim guidance would approve of an exclusion of all infertility treatments, even if it affected disabled employees disproportionately.

Even if courts conclude that all infertility is a disability, the ADA's insurance exception might still apply because the act allows for benefits exclusions that are justified by risk classification generally employed by the insurance industry. The ADA provides that the act should not be construed to prohibit or restrict an employer from using traditional risk calculations indeciding what benefits to provide. [FN37]

This exception is unavailable, however, if the employer uses it as a subterfuge to evade the purposes of the ADA. [FN38] This poses an unresolved problem, because the statute does not define "subterfuge," and the EEOC's guidance on the definition was rejected by the Krauel court.

The EEOC interim guidance defines subterfuge as a disability-based disparate treatment that is not justified by the risks for costs associated with the disability. [FN39]

The 8th Circuit rejected this definition, relying instead on Ohio PERS v. Betts, [FN4O] in which the Supreme Court rejected a definition of subterfuge similar to that used in the ADA.

The 8th Circuit adopted the Betts definition, and held that, for a benefits limitation to be a subterfuge, it must be used to discriminate in some nonfringe benefit aspect of the employment relationship. [FN41] The definition ultimately adopted will likely have a major impact on the issue of health plans under the ADA, and certainly will be the focus of a great deal of future litigation.

FNa. Mr. Friedman is a partner in the New York office of Chicago's Mayer, Brown & Platt. He represents management in labor and employment matters. Ms. Phillips is managing director and global head of human resources of Canadian
Imperial Bank of Commerce Wood Gundy. Joseph E. Gehring Jr., an associate at Mayer, Brown & Platt, assisted in the preparation of this article.

FN1. 95 F.3d 674 (8th Cir. 1996).

FN2. Americans With Disabilities Act of 1990, 42 U.S.C. 12102(2)(A).

FN3. Paul Zarutski and Robert Rubin, "Balancing Costs & Quality," Business & Health, Dec. 1, 1994, at 56.

FN4. Barbara Whitaker, "Infertility is a New Focus of Workplace Lawsuits," N.Y. Times, Apr. 21, 1996 at 12.

FN5. 29 U.S.C. 1144.

FN6. Kristin Davis, "The Agonizing Price of Infertility," Kiplinger's Personal Finance Magazine, May 1996, at 5.

FN7. Id.

FN8. 42 U.S.C. 12112(a).

FN9. The EEOC interprets the provision to require employers to provide the same coverage to workers with disabilities as it does to employees without disabilities, and as prohibiting employers from making disability-based distinctions with regard to what coverage is offered. EEOC Americans With Disabilities Act Technical Assistance Manual, 1-7.9.

FN10. 95 F.3d 674 (8th Cir. 1996).

FN11. 881 F. Supp. 240 (E.D. La. 1995), aff'd, 79 F.3d 1143 (5th Cir. 1996).

FN12. 42 U.S.C. 12102(2)(A).

FN13. 29 C.F.R. 1630.2(h)(1).

FN14. 95 F.3d at 677.

FN15. Id., citing 29 C.F.R. 1630.2(i).

FN16. Id.

FN17. 881 F. Supp. at 243-4, citing 29 C.F.R. 1630.2(j)(3)(i).

FN18. Id. at 243.

FN19. 858 F. Supp. 1393 (N.D. Ill. 1994).

FN2O. 982 F.2d 222 (7th Cir. 1992).

FN21. Id. at 1404-05, The Rehabilitation Act, 29 U.S.C. 701 et seq., predates the ADA and applies to the U.S. government and federally funded programs. The 7th Circuit did not need to rule in McWright on whether infertility is a
handicap because the employer had conceded that point.

FN22. 916 F. Supp. 797, 804 (N.D. Ill. 1996).

FN23. 911 F. Supp. 316 (N.D. Ill. 1995).

FN24. Id. at 322.

FN25. H.R. Rep. No. 101-485 (Part III), 101st Cong., 2d Sess. (1990), reprinted in U.S.C.C.A.N. 445; S. Rep. No. 101-116, 101st Cong., 1st Sess. (1989); 29 C.F.R. 1630.2(h)(1).

FN26. Pacourek, 858 F. Supp. at 1404.

FN27. H.R. Rep. No. 101-485 (Part II), 101st Cong., 2d Sess. (1990), reprinted in 1990 U.S.C.C.A.N. 267, 334.

FN28. Anderson v. Gus Mayer Boston Store, 924 F. Supp. 763 (E.D. Tex. 1996); Abbott v. Bragdon, 912 F. Supp. 580 (D. Maine 1995); Doe v. Kohn Nast & Graf P.C., 862

F. Supp. 1310 (E.D. Pa. 1994); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376 (C.D. Cal. 1986).

FN29. 862 F. Supp. 1410.

FN3O. Id. at 1320.

FN31. EEOC Interim Guidance on the Application of the Americans With Disabilities Act of 1990 to Disability-Based Distinctions in Employer-Provided Health Insurance, EEOC Compliance Manual (CCH) para. 6902 ("EEOC Interim Guidance") .

FN32. 42 U.S.C. 12201(c).

FN33. Id.

FN34. EEOC Interim Guidance.

FN35. Id.

FN36. Id.

FN37. 42 U.S.C. 12201(c).

FN38. Id.

FN39. EEOC Interim Guidance.

FN4O. 492 U.S. 158.

FN41. 95 F.3d at 678-79.

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REVIEW ARTICLE

CURRENT CONCEPTS

THE INFERTILE COUPLE

HOWARD W. JONES, JR., M.D.,

AND JAMES P. TONER, M.D., PH.D.

MOST adults have life plans that include children. When those who desire children find their efforts unsuccessful, frustration, despair, and helplessness are common and debilitating consequences. In this article we survey the scope of the problem of infertility, its current therapies, and the future prospects.

SCOPE OF THE PROBLEM

In the United States, surveys conducted by the National Center for Health Statistics estimate that in 1988, 8.4 percent of women 15 to 44 years of age, or 4.9 million women, had an impaired ability to have children.[1] Of these women, 2.2 million had no children (primary infertility), and 2.7 million had at least one child (secondary infertility).' Approximately 25 percent of women have an episode of infertility at some point during their reproductive life.[2,3] The rates were similar in surveys conducted in 1965, 1976, and 1982.[4-6]

Since 1988 the problem of infertility has increased in several ways.[7] First, there are more infertile women in

the population. The large increase in the number of women 35 to 44 years of age (4 million more in 1988 than in 1982) means that there has been an increase of 37 percent in the number of childless women in that age group.[1] Second, a larger proportion of infertile couples now seek treatment. About 43 percent of women with impaired fertility obtain help for their infertility.[8] In 1988, 1.35 million women consulted physicians about reduced fertility; they accounted for 2.3 percent of U.S. women of reproductive age and 4.6 percent of married women.[1] Approximately 24 percent received advanced treatment (tubal surgery, insemination, ovulation induction, or in vitro fertilization).[8] Women with primary infertility were twice as likely to obtain treatment as those with secondary infertility (51 percent vs. 22 percent).[4] The results were similar in a British population[7]

About half of couples with infertility eventually conceive. Several factors markedly affect the likelihood of pregnancy in a particular couple, however, including the duration of infertility,[10] the age of the woman[11] (Fig. 1), and the cause of the infertility[9,10,13] (Table 1). Contemporary methods of assisted reproduction have increased the overall pregnancy rate.[14-16]

A surprising number of pregnancies occur independently of treatment,[10] especially when bilateral tubal obstruction, azoospermia, and prolonged amenorrhea are absent. Each month, approximately 3 percent of couples with unexplained infertility conceive on their own.[9,17] Not only does this provide some encouragement to couples who may not have access to an infertility specialist, but it also calls into question the validity of many widely used tests and therapies. The value of several such tests and therapies has never been clearly established in clinical trials.[18-20] The Cooperative Multicenter Reproductive Medicine Network, a nationally based collaborative study group funded by the National Institutes of Health, was established in 1990 to correct these shortcomings.[21]

(American Family Physician 9/1/96)

The Infertile Couple

PATRICIA TRANTHAM, M.D., Kaiser Permanente

Infertility is generally defined as the inability to conceive after one year of unprotected, adequately timed intercourse. Causes of infertility include ovulatory dysfunction, tubal factors, peritoneal factors and uterine factors, as well as male factors that are the sole or contributing causes of infertility in up to 40 percent of infertile couples. Reasonable treatment managed by a family physician includes patient education and counseling, and therapy with clomiphene, bromocriptine and progesterone. For treatment beyond this level, referral to an infertility specialist should be considered.

Infertile couples often consult their family physician, who is especially well-suited to initiate evaluation and early treatment. Prompt referral is equally important if the infertile couple's evaluation and treatment extends beyond the expertise of the family physician.

Definition and Scope of Problem

The generally accepted definition of infertility is inability to conceive after one year of unprotected, adequately timed intercourse.[1,2] Conception rates are 20 to 25 percent per month for normal couples, 95 percent of whom conceive within one year. Couples with primary infertility do not achieve pregnancy; those with secondary infertility do not conceive within one year after having previously achieved pregnancy. In general, primary and secondary infertility are evaluated by the same methods.

The incidence of infertility in developed countries is estimated at 10 percent to 15 percent.[1,3] Nearly 5 million women in the United States report decreased ability to conceive: 2.2 million have primary infertility; 2.7 million have secondary infertility. Twenty-five percent of all women report isolated episodes of infertility.[3-5] The inability to conceive increases with age.

In recent years, the number of women with infertility problems has increased. The actual rate of infertility has increased only in women 20 through 24 years of age.[6] The incidence of sexually transmitted diseases that result in adhesions and tubal dysfunction has increased, especially in upper socioeconomic groups,[6,7] and this possibly accounts for most of the increased infertility in the 20- to 24-year-old group.

Many women are postponing childbearing and are attempting conception after the age of 35[3,8] which carries a higher risk for endometriosis, adverse infectious and genetic exposure, ovulatory dysfunction and other age-specific decreased fertility factors.[6,8]

More couples seek medical evaluation and treatment for infertility because advanced technology is now available.[7,8] Adoption, the alternative to childbearing, has become more difficult, taking from 18 to 24 months to accomplish and costing $10,000 to $15,000.[7,9] Of the 1.35 million women who consulted a physician for infertility problems in 1988, about one-half conceived spontaneously in the next year.[10] About 24 percent received advanced treatments for infertility,[3] and the percentage continues to increase.

(The American Journal of Medicine Volume 80)

Frequency of Nonparenteral Occupational Exposures to Blood and Body Fluids Before and After Universal Precautions Training

BARBARA J. FAHEY, B S.N., DELORIS E. KOZIOL, Ph.D., STEVEN M. BANKS, Ph.D., DAVID K. HENDERSON, M D. . *Bethesda, Maryland*

PURPOSE: During annual periods before and after Universal Precautions training, we compared the frequency of health care workers' self-reported cutaneous exposures to blood and various body substances from any patient and from patients presumed infected with human immunodeficiency virus type 1 (HIV-1).
SUBJECTS AND METHODS: Self-reported cutaneous exposures to blood, sputum, urine, feces, and other body substances were evaluated separately in 559 workers during the first survey and 269 workers. during the second.
RESULTS: Mean annual blood exposures decreased from 35.8 to 18.1, and mean annual exposures to all substances decreased from 77.8 to 40.0 ($p < 0.001$ for both determinations).

* * *

CONCLUSIONS:These data that Universal Precautions training significantly decreased but did not eliminate cutaneous exposures to blood and body substances, The results further suggest that the risk for HIV-1 infection associated with cutaneous exposures is substantially lower than the risk associated with parenteral exposures.

* * *

Supreme Court, U.S.
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No. 97-156

In the Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,
PETITIONER,
v.
SIDNEY ABBOTT ET AL.,
RESPONDENTS.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

RESPONDENT SIDNEY ABBOTT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

BENNETT H. KLEIN
Counsel of Record
GAY & LESBIAN ADVOCATES & DEFENDERS
294 Washington Street, Suite 740
Boston, Massachusetts 02108-4608
(617) 426-1350

DAVID G. WEBBERT
JOHNSON, WEBBERT & LAUBENSTEIN
160 Capitol Street
P.O. Box 29
Augusta, Maine 04332-0029
(207) 623-5110

Attorneys for Respondent Sidney Abbott

Blanchard Press, Inc., Boston, Mass — Law Printers (617) 426-6690

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QUESTIONS PRESENTED FOR REVIEW

1. Whether plaintiff Sidney Abbott, a person who is infected with HIV, is an individual with a disability under the Americans with Disabilities Act (ADA)?

2. Whether the lower courts properly reviewed the factual record in rejecting the Petitioner's "direct threat" defense -- when public health authorities and the American Dental Association agree that it is safe to provide such treatment, and HIV transmission from a patient to dentist has never been demonstrated?

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OCTOBER TERM, 1997

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RESPONDENT SIDNEY ABBOTT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF THE CASE

This action was brought under the Americans with Disabilities Act (ADA) to enjoin defendant Randon Bragdon, a dentist, from applying his blanket policy of refusing under any circumstances to provide routine dental care to patients, including the plaintiff, Sidney Abbott, solely because they have tested positive for the human immunodeficiency virus (HIV).

In contrast to popular perception, HIV is difficult to transmit. According to Dr. Bragdon's own expert, "HIV is

a disease of low infectivity." App. 257.[1] Although over one billion dental procedures have been performed by over 250,000 dental health care workers in the past fourteen years, and approximately 1,000,000 individuals in the United States are estimated to be infected with HIV, there has never been a documented case of HIV transmission from infected patient to dental health care worker, nor from infected patient to noninfected patient. App. 105, 112.

The American Dental Association, the leading dental association in the United States, has had a policy since 1988 which states:

> Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection for both patients and dental personnel.

American Dental Association's *Policy Statement on AIDS, HIV Infection and the Practice of Dentistry* (1988: 457; 1991: 591), App. 273.[2]

On September 16, 1994, Sidney Abbott arrived at Dr.Bragdon's office for a previously-scheduled appointment. App. 240-241. In response to written and verbal inquiries

[1] "App." refers to the Joint Appendix filed with the Court of Appeals.

[2] *See also Amicus Curiae* Brief in the Court of Appeals of Rhode Island Department of Public Health, Department of Public Health of Commonwealth of Massachusetts, Bureau of Health of the Maine Department of Human Services, American Public Health Association, Association of State and Territorial Dental Directors, and Association of State and Territorial Health Officials (the "Public Health Brief") ("There is a uniform consensus among public health authorities, including the United States Centers for Disease Control and the Public Health Amici submitting this brief . . . that it is safe to provide routine dental care to patients with HIV in a private dental office with standard infection control procedures used for all patients.").

from Dr. Bragdon about her medical history and HIV status, Ms. Abbott informed him that she had tested positive for HIV. Dr. Bragdon examined Ms. Abbott and diagnosed a cavity which required a filling. App. 241. Dr. Bragdon told Ms. Abbott that he was not willing to fill her cavity in his office because she has HIV. App. 227 (p. 268).

Although Dr. Bragdon represented to Ms. Abbott on September 16, 1994 that he would treat her in a hospital setting, Dr. Bragdon had not even applied for privileges to treat patients at any hospital. On November 1, 1994, more than one month after Ms. Abbott filed a complaint against Dr. Bragdon at the Maine Human Rights Commission, Dr. Bragdon for the first time applied for hospital privileges at Down East Community Hospital in Machias, Maine. App. 278. Machias is approximately a two-hour drive from Bangor, and Dr. Bragdon insisted that Ms. Abbott would have to pay for the added cost of the surgical operatory there. App. 227. Defendant Bragdon's application for hospital privileges was never granted and even today he lacks privileges to treat patients at any hospital.[3]

Ms. Abbott filed a complaint in the United States District Court for the District of Maine in December, 1994 and the United States intervened in support of Ms. Abbott's position. After discovery was completed, the District Court granted summary judgment for Ms. Abbott and plaintiff-intervenors United States and Maine Human Rights Commission on all liability issues. *See Abbott* v. *Bragdon*, 912 F. Supp. 580 (D. Me. 1995). (31a) (referring to the Appendix to the Petition).

[3] Moreover, the undisputed testimony in the District Court demonstrated that it is equally safe to treat a dental patient with HIV in a private dental office like Dr. Bragdon's as in a hospital setting. Dr. Bragdon's expert stated that the only way in which a hospital setting reduces the risk of HIV transmission to a dentist is that Dr. Bragdon would have more "time to deal with the patient" in a hospital setting. App. 264 (pp. 156-157).

The District Court ruled that Ms. Abbott is disabled under the ADA because HIV is a physical impairment that substantially limits her major life activity of reproduction. 912 F. Supp. at 585-587. (31a-41a).[4] The District Court rejected Dr. Bragdon's defense that the provision of routine dental care in his office rises to the level of a "direct threat to the health or safety of others" under the ADA. (41a-52a). The District Court determined that Dr. Bragdon had presented only "speculation," "conjecture," and "tangential statistics" to support his assertion that the performance of a dental procedure, such as filling a cavity, would create a significant risk of HIV transmission. 980 F. Supp. at 588-589. (44a-45a).

Dr. Bragdon appealed the District Court decision to the United States Court of Appeals for the First Circuit. Based on a careful examination of evidence in the record, the Court of Appeals ruled that Sidney Abbott is protected from discrimination under the ADA because HIV is a physical impairment[5] which substantially limits the major life activity of reproduction. 107 F.3d at 939-942. (5a-15a). The Court reached this conclusion based on Ms. Abbott's own uncontradicted testimony that after she learned that she tested positive for HIV, she decided not to have children because of the risk of infecting the child. 107 F.3d at 941. (13a). In addition, the Court of Appeals, like the District Court, examined all of Dr. Bragdon's evidence on his "direct threat" defense and concluded: "Each piece of evidence is too speculative or tangential (or in some instances, both) to create a genuine issue of material fact." *Id.* at 947. (29a). The Court of Appeals reviewed the record for cumulative proof and was "satisfied that the evidentiary proffers canvassed above, insufficient in themselves, are likewise insufficient in combination to call into legitimate question the lower court's entry of summary judgment." 107 F.3d at 948. (29a). On April 22, 1997, the Court of Appeals denied Dr. Bragdon's petition for rehearing and suggestion for rehearing en banc.

[4] Contrary to Dr. Bragdon's assertions [Petition, at 7 n.6], Ms. Abbott also argued in both the District Court and the Court of Appeals that she is covered under the "regarded as" prong of the statutory definition of disability in the ADA because Dr. Bragdon excluded her from dental services based on his misperception that HIV is too contagious. *See* Brief in First Circuit of Sidney Abbott at pp. 31-34. The United States also made this same "regarded as" argument below.

[5] There was undisputed expert testimony submitted in the District Court that from the initial onset of infection, HIV results in abnormalities to the blood, lymph and immune systems which begin to destroy an individual's ability to fight off infection. App. 306.

REASONS FOR DENYING THE PETITION

I. THERE IS NO NEED FOR THIS COURT TO REVIEW THE LOWER COURTS' DETERMINATIONS THAT PLAINTIFF SIDNEY ABBOTT IS AN INDIVIDUAL WITH A DISABILITY UNDER THE ADA.

A. *This Case is Unsuitable For This Court to Decide if Reproduction is a "Major Life Activity" Under the ADA.*

This Court should decline to decide if reproduction is a major life activity for two reasons. *First*, the issue has only begun to be reviewed by courts of appeals in the past year and only one court of appeals has issued a ruling contrary to the First Circuit. *See Krauel* v. *Iowa Methodist Medical Center*, 95 F.3d 674 (8th Cir. 1996).[6] The First Circuit correctly held that reproduction is a "major life activity" under the ADA. 107 F.3d at 939-941. (6a-14a). Analyzing the statu-

[6] In the Petition, defendant Bragdon seeks to inflate this narrow difference of opinion by citing district court decisions and decisions which contain only dicta. Petition at 5-6, n. 3-5. In addition, defendant cites *Zatarain* v. *WDSU-TV, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd*, 79 F.3d 1143 (5th Cir. 1996). Because *Zatarain* was affirmed without opinion, it is not a ruling as to whether reproduction is a major life activity under the ADA. *See* Local Rule 47.6 of the United States Court of Appeals for the Fifth Circuit (affirmance without opinion has no precedential value and may be based on any number of grounds).

tory text, the Court of Appeals noted that "major" denotes "comparative importance" and concluded that "reproduction, which is both the source of all life and one of life's most important activities, easily qualifies under that criterion." 107 F.3d at 939. (8a).[7]

By contrast, the *Krauel* decision is fundamentally flawed because that court ignored the starting place for statutory interpretation -- the broad language of the statute itself -- and instead focused solely on one narrow section of the regulations.[8] This Court should allow further development of the law by the courts of appeals before considering the issue whether reproduction is a major life activity under the ADA. *See, e.g., McCray* v. *New York*, 461 U.S. 961, 963 (1983) (Stevens, J.) (certiorari denied when issue presented requires "further study" in lower courts "before it is addressed by this Court").

Second, this is not a suitable case for this Court to decide whether reproduction is a "major life activity" under the ADA because that issue is not outcome determinative in this case. Ms. Abbott and the United States both argued below, in the alternative, that she satisfied the definition of disability under the ADA because she was "regarded as" disabled. *See* 42 U.S.C. § 12102(2) (C). This alternative theory of disability is strongly supported by this Court's prior decision in *School Board of Nassau County* v. *Arline*, 480 U.S. 273 (1987). In

[7] The Court of Appeals also based its conclusion on Congress's intent to give a broad definition to the term "disability" and the language of the ADA's implementing regulations. 107 F.3d at 939-940. (8a-9a). The First Circuit further noted this Court's recognition of the right to conceive and raise children as "essential" and "basic." 107 F.3d at 939 (*quoting Stanley* v. *Illinois*, 405 U.S. 645, 651 (1973)). (8a).

[8] The regulations define "major life activities" to mean "functions *such as* caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. Section 36.104 (emphasis added). As the First Circuit observed, the list is not meant to be exclusive and "reproduction—one of the most natural endeavors—fits comfortably within its sweep." 107 F.3d at 940. (9a).

Arline, this Court emphasized "that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from the actual impairment" and that it would be unfair to allow a defendant "to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment." *Arline*, 480 U.S. at 282, 284 (footnotes omitted). Thus, even if this Court were to rule against Ms. Abbott on the procreation issue, she could still prevail on her "regarded as" claim which the First Circuit did not need to address. If this Court wishes to resolve the procreation issue, it should wait for a case in which that issue is outcome determinative.

B. *There is No Conflict Among the Courts of Appeals About Whether an Individual Who is Infected With HIV, But Who is Asymptomatic, is "Disabled" And Therefore Protected By the ADA.*

The Court should not grant certiorari on Petitioner's second issue because the First Circuit did not base its decision that Ms. Abbott is disabled under the ADA on the holding that HIV is a "per se" disability and because the Fourth Circuit has not issued a majority decision on this issue. Rather, the First Circuit decided that Ms. Abbott is disabled based on her testimony of a substantial limitation to the major life activity of reproduction. 107 F.3d at 939-942. (6a-15a)[9].

Contrary to claims of defendant Bragdon, no clear conflict exists among the other courts of appeals concerning whether all persons with HIV are "per se" disabled under the ADA. *See* Petition at 10. The Fourth Circuit, which Bragdon claims has held that asymptomatic individuals with HIV are not "per

[9] The First Circuit added a "final observation," and Ms. Abbott strongly agrees, that Congress's intent that HIV-infected individuals be covered under the ADA bolsters the court's independent conviction based on the record that Ms. Abbott is disabled under the ADA. 107 F.3d at 942. (15a).

se" disabled, has not taken a clear stand on this issue. In *Runnebaum* v. *Nationsbank of Md., N.A.*, 123 F.3d 156 (4th Cir. 1997), 1997 WL 465301 (August 15, 1997), the only majority decision reached by the Court en banc affirmed the District Court's dismissal of the case on the grounds that the plaintiff did not forecast sufficient evidence to survive summary judgment that he was fired from his job for a discriminatory reason. *See* Opinion of Williams, J. and Concurring Opinion of Hamilton, J.

Less than a majority of the Court (six of twelve judges) joined an opinion holding that the plaintiff was not disabled under the ADA, with six members ruling that the issue was not properly before the Court. *See* Dissent of Michael, J. and Concurring Opinion of Hamilton, J. This unresolved internal dispute among the judges of the Fourth Circuit does not warrant review by this Court. *See, e.g., Davis* v. *United States*, 412 U.S. 333, 340 (1974).[10]

Defendant Bragdon does not point to a majority decision of any court of appeals which holds that people with HIV are not protected by the ADA. To the contrary, there has been a virtual consensus of judicial authority that people with HIV are squarely within the protections of the ADA. *See, e.g., Gates* v. *Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994) ("[W]e hold that a person infected with the HIV virus is an individual with a disability within the meaning of the [Rehabilitation] Act"); *Doe* v. *Garrett*, 903 F.2d 1455, 1459 (11th Cir. 1990) (In case where plaintiff had asymptomatic HIV, court stated that "[I]t is well established that infection with AIDS constitutes a handicap for purposes of the [Rehabilitation] Act."), *cert. denied*, 499 U.S. 904 (1991).

[10] Similarly, another Fourth Circuit decision, *Ennis* v. *National Ass'n of Business & Educ. Radio*, 53 F.3d 55 (4th Cir. 1995), provides only dicta on the issue of HIV as a disability. In that case, the Court assumed the existence of a disability for purposes of the ADA because the record was undeveloped on that issue. 53 F.3d at 60. The Court then upheld summary judgment for the employer on independent grounds. 53 F.3d at 61-62.

To the extent that some judges in *Runnebaum* interpret the definition of disability in the ADA as excluding people with HIV, the most that can be said today is that such an interpretation is an aberrant view which does not even reflect the majority of the Fourth Circuit. The Fourth Circuit will likely have an opportunity to revisit this issue in the future. This Court should decline to address the issue of HIV as a protected disability under the ADA when, in fact, no real split of authority exists. The Court should wait until such time as there may be a clear conflict in the courts of appeals.

II. DEFENDANT BRAGDON ALLEGES ONLY THAT THE COURT OF APPEALS MADE ERRONEOUS FACTUAL DETERMINATIONS ON SUMMARY JUDGMENT ON THE "DIRECT THREAT" ISSUE.

This Court should not revisit the careful, record-based determinations of the District Court and Court of Appeals, which found that Bragdon presented only conjecture about the future possibility of a risk which has never occurred in the fourteen years of the HIV epidemic. *See* United States Supreme Court Rule 10 ("A Petition is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law"); *Graver Mfg. Co.* v. *Linde Co.*, 336 U.S. 271, 275 (1949) (Supreme Court should not "undertake to review concurrent findings by two courts below in the absence of a very obvious and exceptional show of error"). The Court therefore should deny the Petition on the "direct threat" issue even if the Court were to grant the Petition on questions one or two in the Petition.[11]

[11] Dr. Bragdon waived below any claim that he was an expert on infection control practices or infectious diseases and thus his third and fourth questions presented are not properly raised on this record. Similarly, on appeal he waived any reliance on his only expert witness, Dr. Sanford Kuvin. 107 F.3d at 946 n.8. (24a).

Defendant Bragdon does not cite any Court of Appeals decision or any decision of this Court which is in conflict with the First Circuit's determination that he failed to establish that the provision of routine dental care to patients with HIV is a "direct threat." In fact, courts uniformly have ruled that the "direct threat" defense is insufficient as a matter of law to justify a refusal by a dentist to treat a person with HIV.[12]

Rather, defendant Bragdon asks this Court to sift through a "sampling of facts in the record" (Petition, p. 13) and second guess the determinations of the District Court and the Court of Appeals that he presented only conjecture and speculation in support of his "direct threat" defense. The Petition does nothing more than repeat the same list of inaccuracies and mischaracterizations which two lower courts have already rejected. Ms. Abbott will not respond to each false statement in the Petition. As an example of the type of evidentiary leap which characterizes Bragdon's "direct threat" defense, defendant Bragdon points to a Food and Drug Administration (FDA) recommendation that persons who have had contact with a patient's blood refrain from donating blood for a year. Petition at 14-15. That, according to Bragdon, is evidence of a "significant risk" of HIV transmission in dentistry. *Id.* The FDA, however, has not made any determination concerning risks of occupational transmission of HIV to dentists. As the First Circuit correctly observed, the FDA may seek to "avoid minute risks and take unusual precautions even in the absence

[12] *See D.B.* v. *Bloom*, 896 F. Supp. 166, 170 n.6 (D. N.J. 1995) (HIV-positive individual may be safely treated in private dental office which utilizes precautions and "no medically justified reason existed" for discrimination); *United States of America* v. *Morvant*, 898 F. Supp. 1157, 1166-1167 (E.D. La. 1995) (rejecting "direct threat" argument and noting a "plethora of expert testimony" that following the CDC recommendations significantly mitigates any risk); *Minnesota* v. *Clausen*, 491 N.W.2d 662 (Minn. Ct. App. 1992) (noting the overwhelming evidence, including the American Dental Association policy, that "HIV-positive patients may be safely treated in a private dental office which utilizes universal precautions").

of actual evidence of danger" to safeguard the blood supply. 107 F.3d 946. (24a-25a).[13]

In addition, many of defendant Bragdon's claims merely state that a risk of HIV transmission in dentistry exists because dentists sometimes come into contact with a patient's blood.[14] The truism that a dentist may sometimes come into contact with a patient's blood, however, does not come close to providing any evidence that HIV has ever been transmitted from patient to dentist, nor does it illuminate the degree of probability of such occurrence. Exposure to blood is not synonymous with infection or actual transmission of HIV. App. 343-344. HIV is a virus of low infectivity, and any exposure to a patient's blood during a dental office procedure occurs in small amounts which have never been shown to result in transmission of HIV. App. 344, 394. Similarly, while Bragdon claims that HIV can be transmitted by aerosols from the high speed dental drill (Petition at 19), even Dr. Bragdon's own expert testified that "there's no evidence to suggest that aerosol spray can transmit HIV". App. 268.; 107 F.3d at 946-947. (26a-27a).[15]

Dr. Bragdon claims that he only wanted to take the same precautions as are routinely taken by dentists in "big cities"

[13] The Petition also claims that the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard provides evidence of a "significant risk" of HIV transmission in dentistry, although Bragdon never made any such claim in the Court of Appeals and thereby waived this argument. Petition at 13-15. In any event, OSHA found that the use of universal precautions "substantially reduces" the risk of transmission of HIV and Hepatitis B in the health care setting. *See* 56 Fed. Reg. 64004, 64038 (1991).

[14] *See, e.g.*, Petition at 14, 15-16 (claiming that "universal precaution" infection control procedures do not entirely eliminate all exposure to patients' blood).

[15] Dr. Bragdon cited a 1991 study by Johnson and Robinson which, on its face, states only that it raises the question of HIV transmission through aerosols and that "[f]urther work is required to determine whether such a risk exists." App. 424.

(Petition at 20) and that "providers specifically preferred by HIV-infected patients take significant additional precautions to protect themselves." Petition at 30. There is no support anywhere in the record for these assertions.[16] Dr. Bragdon's own expert testified that he was not aware of any hospital which automatically uses different infection control procedures beyond universal precautions for HIV-positive patients. Deposition of Sanford Kuvin, M.D., Docket No. 58, p. 263. In addition, Dr. Bragdon's expert was not aware of any authority for the view that all patients with HIV should be referred outside the dental office for routine dental care. App. 255. Bragdon's expert specifically declined to endorse Dr. Bragdon's policy of automatic referral of HIV-positive dental patients. App. 255.[17]

The Court of Appeals' conclusion is consistent with all other judicial authority and the scientific consensus of the United States Centers for Disease Control, the American Dental Association and numerous other public health authorities, including those submitting the Public Health Brief in the First Circuit. *See supra*, n.2. Indeed, if Dr. Bragdon's speculative ideas were sufficient to be the basis for a finding of "direct threat," then any hospital could lawfully refuse to draw blood or insert an intravenous line in a patient with HIV. The result would be a medical disaster for the almost one million people in this country living with HIV and a public health disaster for society in general.

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[16] As additional evidence of how defendant Bragdon misstates the record, his Petition references an anecdote from one of Dr. Bragdon's colleagues and a "confidential document" lodged with the Court, neither of which were in the record below or provide any evidence to support his "direct threat" defense.

[17] Dr. Bragdon claimed that he had the absolute right to refuse treatment of Ms. Abbott, not that a hospital procedure was safer than an office procedure. Therefore, the Court of Appeals did "not address whether it is illegal under the ADA for a dentist to take additional precautions when treating HIV-infected patients." 107 F.3d 934 at 942 n.4. (16a). Dr. Bragdon waived below any claim that "hospital treatment was significantly safer than office treatment." *Id.*

CONCLUSION

For the reasons set forth herein, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

BENNETT H. KLEIN
Counsel of Record
GAY & LESBIAN ADVOCATES
& DEFENDERS
294 Washington Street, Suite 740
Boston, Massachusetts 02108-4608
(617) 426-1350

DAVID G. WEBBERT
JOHNSON, WEBBERT & LAUBENSTEIN
160 Capitol Street
P.O. Box 29
Augusta, Maine 04332-0029
(207) 623-5110

Attorneys for Respondent
Sidney Abbott

(5)

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Supreme Court of the United States
October Term 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT ET AL.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit

PETITIONER'S REPLY BRIEF

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER
RUDMAN & WINCHELL
Attorneys for Petitioner
84 Harlow Street
P.O. Box 1401
Bangor, Maine 04402-1401
(207) 947-4501

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PETITIONER'S REPLY BRIEF

Petitioner Randon Bragdon, D.M.D., replies to respondent Sidney Abbott's brief in opposition as follows:

First, Ms. Abbott acknowledges the direct conflict between courts of appeals, and among many lower federal courts, on whether reproduction is a major life activity under the ADA, and provides no rationale as to *why*, in this instance, it makes sense for the Court to insist on further development of the law before considering the issue.

Second, Ms. Abbott has never identified a major life activity in which she was allegedly "regarded as" substantially limited. Therefore, contrary to her argument, she has no viable claim under *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), that she was "regarded as substantially limited in a major life activity."

Third, *Arline* holds that Gene Arline was disabled *in spite of the fact* she was contagious, *not because* she was contagious. The Court further explained that Ms. Arline was actually disabled under the statute because of her record of being substantially limited in a major life activity. *Id.* at 280-281. Thus, contrary to Ms. Abbott's argument, *Arline* is not strong support for a theory she is disabled because Dr. Bragdon regarded her as infectious.

Fourth, Dr. Bragdon pressed below the third and fourth questions presented in his petition. *See* Appellant's Brief in First Circuit, pp. 29-32. Ms. Abbott presented arguments that Dr. Bragdon waived these issues, in part by not relying for summary judgment purposes on his testimony as an expert on certain issues. *See* Appellee's Brief, p. 4. Dr. Bragdon replied to these waiver arguments. *See* Appellant's Reply Brief, pp. 12 n.11, 21-23. The Appeals Court rejected the waiver arguments, and passed on questions three and four. *See* pp. 17a-22a of the petition appendix. Contrary, therefore, to Ms.

Abbott's argument in footnote eleven of her opposition to the petition, questions three and four of the petition are properly raised on this record. *See United States v. Williams*, 504 U.S. 36, 41 (1992) ("Our traditional rule, as the dissent correctly notes, precludes a grant of certiorari only when 'the question presented was not pressed or passed upon below.'" (citation omitted)).

Fifth, Ms. Abbott misrepresents that this is a refusal to treat case, and misrepresents the circumstances and facts concerning Dr. Bragdon's willingness and ability to perform invasive procedures on Ms. Abbott in local hospitals and/or hospital-like settings.

Sixth, Ms. Abbott omits relevant evidence in the record concerning how it is safer to treat HIV-infected individuals in a hospital-like setting.

WHEREFORE, Dr. Bragdon requests that the Court agree to review the questions presented in this case.

Respectfully submitted,

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER
RUDMAN & WINCHELL
Attorneys for Petitioner
84 Harlow Street
P.O. Box 1401
Bangor, Maine 04402-1401
(207) 947-4501

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PETITIONER'S SUPPLEMENTAL BRIEF

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER
RUDMAN & WINCHELL
Attorneys for Petitioner
84 Harlow Street
P.O. Box 1401
Bangor, Maine 04402-1401
(207) 947-4501

PETITIONER'S SUPPLEMENTAL BRIEF

Petitioner Randon Bragdon, D.M.D., has petitioned for review of whether asymptomatic individuals infected with HIV are per se disabled under the Americans with Disabilities Act (ADA). On page 10, note 8, of his petition, Dr. Bragdon cites Runnebaum v. NationsBank of Maryland, N.A., 95 F.3d 1285, 1289 (4th Cir. 1996), reh'g en banc granted, opinion vacated (Dec. 3, 1996). On August 15, 1997, the Fourth Circuit issued its en banc decision in Runnebaum. Runnebaum v. NationsBank of Md., N.A., ___ F.3d ___ (4th Cir. 1997), 1997 WL 465301 (Aug. 15, 1997).

The en banc Runnebaum majority affirmed a summary judgment under the ADA against William Runnebaum, an asymptomatic individual infected with HIV. The Runnebaum dissent fairly characterizes the majority as having created a "per se rule excluding those with asymptomatic HIV from the protection of the ADA." Id. at ___ (Michael, J., dissenting).

The sharply divided en banc opinion in Runnebaum further illustrates the conflict among the circuits as to the status under the ADA of asymptomatic persons with HIV. Wherefore, Dr. Bragdon requests that the Court grant his petition for a writ of certiorari.

Respectfully submitted,

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER
RUDMAN & WINCHELL
Attorneys for Petitioner
84 Harlow Street
P.O. Box 1401
Bangor, Maine 04402-1401
(207) 947-4501

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Petitioner,

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Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit

BRIEF OF THE *AMICUS CURIAE* THE AMERICAN DENTAL ASSOCIATION IN SUPPORT OF PETITIONER RANDON BRAGDON, D.M.D.'S PETITION FOR WRIT OF CERTIORARI

Peter M. Sfikas, Esquire
Counsel of Record
Mark S. Rubin, Esquire
Jill A. Wolowitz, Esquire
AMERICAN DENTAL ASSOCIATION
211 East Chicago Avenue
Chicago, IL 60611
Phone: (312) 440-2500

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INTEREST OF THE AMICUS

The AMERICAN DENTAL ASSOCIATION (the "Association"), an Illinois not-for-profit corporation founded in 1859, is the leading dental association in the United States with over 140,000 member dentists representing approximately 75% of this nation's active licensed dentists. The stated object of the Association, as set forth in its Constitution, is to "encourage the improvement of the health of the public and to promote the art and science of dentistry." The Association has a vital interest in matters which affect the oral health of the public, and a long record of educating dentists and the public about HIV/AIDS and the safety of the dental office.

The Association urges this Court to grant the portion of Petitioner Randon Bragdon, D.M.D.'s Petition for Writ of Certiorari pertaining to the definition of "disability" under the Americans with Disabilities Act (the "Act").[1] Resolution by this Court of whether persons with asymptomatic HIV-disease have a "disability" under the Act, when their claim of "disability" status rests on an asserted inability to reproduce, is needed to help clarify the legal obligations of health care providers under the Act.

All parties to the Petition have consented to the filing of this Brief, as reflected in the consent letters separately submitted to this Court. Pursuant to the Court's rules, the Brief brings to the attention of the Court relevant matter, from the

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[1] No counsel for a party authored any part of this *amicus curiae* brief, and no person or entity other than the *amicus curiae* made a monetary contribution to the preparation or submission of this brief. (Rule 37.6 of the Supreme Court of the United States.)

perspective of America's leading dental association, not already brought to the Court's attention by the Petitioner. (Rule 37.1 of the Supreme Court of the United States.) Every effort has been made to avoid or minimize duplication with the Petition.

The brief does not in any way challenge or undermine long-standing Association policy concerning the safety of the dental office and/or the treatment of HIV-infected individuals.[2] Nor does it challenge whether someone who exhibits symptoms of HIV, including AIDS, is "disabled."

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[2] As set forth in our *amicus curiae* brief below, the Association stands by its self-explanatory, cornerstone policies that (1) HIV-individuals should be treated with compassion and dignity, (2) there is little risk of transmission of HIV through dental treatment if recommended infection control procedures are routinely followed, (3) patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed, (4) such infection control procedures provide protection both for patients and dental personnel, and (5) a decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. American Dental Association's Policy Statement on AIDS, HIV Infection and the Practice of Dentistry (1988:457; 1991:591), Appendix at 273; ADA Principles of Ethics and Code of Professional Conduct, Section 1-A, Patient Selection, Advisory Opinion 1 (1988), Appendix at 276. In addition, after the filing of our brief below, the Association established policies Efficacy of Universal Precautions and Policy Statement on HIV/AIDS as an Infectious and Communicable Disease providing, *inter alia*, that (6) based on current scientific and epidemiological data, universal precautions continue to be an effective means of reducing blood contacts that can result in disease transmission, minimizing even further the already low risk of bloodborne disease transmission in the dental office, (7) given that data, patients with bloodborne diseases may be treated in the private dental office with no significant risk of disease transmission, provided appropriate infection control procedures are employed and (8) in Association communications on this issue, members be reminded that a patient's HIV/AIDS status is not a justification for refusal of treatment (1996: 734-735).

SUMMARY OF ARGUMENT

Based on our experience assisting dentists trying to comply with the Americans with Disabilities Act (the "Act"), the Association believes that a clear pronouncement by this Court is needed to clarify whether dentists and other health care providers have a legal obligation under the Act to treat individuals with asymptomatic HIV-disease, where a patient's only claim of actual disability is an asserted inability to reproduce, as in the instant case. In view of a circuit court split on the issue of whether reproduction is a "major life activity" under the Act, it is important that this Court squarely address the issue to determine whether individuals with such conditions are entitled to "disability" status under the Act, and to reject a *per se* "disability" rule for HIV. A decision by this Court would help effectuate the educational purposes of the Act[3], and make more clear for providers the scope of their legal obligations.

ARGUMENT

This Court Should Resolve The Split In The Circuits Regarding Whether "Reproduction" Is A "Major Life Activity" Under The Americans With Disabilities Act

Some persons with asymptomatic HIV-disease, like Respondent Ms. Abbott, have claimed "disability" status

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[3] 42 U.S.C. §1201(b) and related agency guidances.

under the Act based on their position that their ability to reproduce is substantially limited by their HIV infection. However, if Ms. Abbott had sought dental care within the jurisdiction of the Fifth or Eighth Circuits, rather than the First, her case might have been decided differently. The reason: a federal appeals court conflict regarding whether "reproduction" is a "major life activity" under the Act.

At least two federal appeals courts have rejected the argument that reproduction is a "major life activity." The court in Zatarain v. WDSU-Television, Inc., 881 F.Supp. 240, 243 (E.D.La. 1995), aff'd, 79 F.3d 1143 (5th Cir. 1996) reasoned that reproduction is not an activity engaged in with the same degree of frequency as the illustrative list of activities in the regulations and therefore treating reproduction as a major life activity under the ADA would be a conscious expansion of the law beyond the province of the court. Likewise, the court in Krauel v. Iowa Methodist Medical Center, 95 F.3d 674, 677 (8th Cir. 1996) held that reproduction is not a "major life activity," agreeing with the Zatarain position that to treat reproduction as a major life activity under the ADA would be a considerable stretch of federal law.

By concluding that reproduction is a "major life activity" under the ADA, the court in Abbott v. Bragdon, 107 F.3d 934, 941 (1st Cir. 1997), is in direct conflict with the above mentioned federal appeals court decisions.

In view of the circuit court split, health care providers have no uniform guidance regarding whether the Act requires them to treat persons with asymptomatic HIV-disease when, like Ms. Abbott, their sole claim of actual disability is based on an asserted inability to reproduce. Accordingly, for millions of Americans – including health care providers,

individuals with asymptomatic HIV-disease, and those who associate with them – there is compelling reason for this Court to hear the case. (Rule 10(a) of the Supreme Court of the United States.)

Absent a resolution of the issue by the Court, health care providers in some Circuits may have a legal obligation to treat certain asymptomatic HIV patients, while providers in other Circuits may not. This leaves the Association's approximately 140,000 member dentists in legal limbo, and we implore the Court to hear this case in order to provide an answer to the important issue of whether an asymptomatic HIV patient is "disabled" because of an asserted inability to reproduce.

This Court Should Determine That The Americans With Disabilities Act Does Not Allow For A Disability *Per Se* Treatment Of Any Condition, Including HIV Disease

This Court should also grant the Petition because the First Circuit's ruling comes dangerously close to the adoption of a disability *per se* rule for HIV disease.[4] Had Congress

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[4] As set forth in Dr. Bragdon's Petition For Writ Of Certiorari, there is arguably a circuit split regarding whether persons with asymptomatic HIV-disease are *per se* disabled under the Act. Petition at 10-11. In amending its original decision, the First Circuit highlighted that "Congress deemed HIV-infected individuals to be disabled under the ADA," quoting from the Act's legislative history that reflected "[p]ersons infected with the Human Immunodeficiency Virus are considered to have an impairment that substantially limits a major life activity, and thus are considered disabled under the first test of the definition...[and] a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual

expressly sought to single HIV/AIDS out for special consideration, that would be one thing. But Congress did not. Rather, in framing the Americans with Disabilities Act, Congress relied upon a definition borrowed from the Rehabilitation Act, passed long before the advent of the AIDS epidemic.[5]

The statutory definition does not enumerate a list of disabilities, but rather begins by characterizing "disability" as a "physical or mental impairment that substantially limits one or more of the major life activities" of the individual in question. 42 U.S.C. § 12102(2)(A). Accordingly, whether any particular plaintiff is disabled under the Act requires an individualized application of a not explicitly defined legal standard as to what constitutes both a major life activity and a substantial limitation of that activity. Indeed, the plain language of the ADA militates against finding HIV disease to be a disability *per se* and compels a case-by-case determination of whether a given individual is disabled by HIV/AIDS. Ennis v. National Ass'n of Business and Educ. Radio, Inc., 53 F.3d 55, 59-60 (4th Cir. 1995).[6]

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relationships." Abbott v. Bragdon, 107 F.3d 934, 942-43 (1st Cir. 1997). According to the Court, the "legislative history thus independently bolsters our conviction that Ms. Abbott is disabled under the ADA." Id. In point of fact, however, this added language risks tilting all other courts towards a *per se* rule for HIV.

[5] H.R. Rep. No. 485, Part 2, 101st Cong., 2nd Sess., 50 (1990).

[6] As this Court well knows, lower courts are struggling with the Act's "disability" definition outside the context of HIV. For example, some courts have held that cancer is a disability, Mark v. The Burke Rehabilitation Hospital, 1997 WL 189124 (S.D.N.Y. 1997); some courts have held it is not. Ellison v.

As set forth in our *amicus* brief below, applying the statutory definition in the instant case leads to one of two results: either Respondent, Ms. Abbott, was not disabled when she sought treatment from Petitioner, Dr. Bragdon, or the determination of disability needed to be made by the trier of fact, rather than on summary judgment.[7]

The Association urges the Court to reject the application of a disability *per se* rule to HIV. Applying a blanket *per se* rule solely for diseases *de jour* can be confusing to the point that those charged with compliance, and the public in general, might genuinely loose confidence in the law, the lawmakers, and the courts that interpret the law. Laws must be consistently and fairly applied to instill public confidence, and compliance with the Act is likely to be optimized if it is applied consistently with respect to all diseases and conditions. Indeed, one of the Act's express purposes is "to provide clear, strong, consistent, enforceable

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Software Spectrum, Inc., 85 F.3d 187, 191 (5th Cir. 1996). Some courts have held that diabetes is a disability, Sarsycki v. United Parcel Service, 862 F.Supp. 336, 340 (N.D.Ok. 1994); some courts have held it is not. Gilday v. Mecosta County, 920 F.Supp. 792, 795 (W.D.Mi. 1996). What these cases all have in common is the application of the Act's "disability" definition to the facts of the particular case. They eschew the application of a *per se* rule.

[7] Based on the record in the instant case, including Respondent's contradictory deposition testimony, reasonable people could disagree as to whether Respondent's ability to reproduce was "substantially limited" by her asymptomatic HIV-infection. Accordingly, the issue of Respondent's alleged "disability" was unsuitable for summary judgment and should have been resolved by the trier of fact.

standards addressing discrimination against individuals with disabilities." 42 U.S.C. § 1201(b)(2) (emphasis added).

This Court should send a clear message that there are no "special" disabilities, and that all diseases and conditions will be judged by the same, apolitical "disability" definition that was time tested long before the advent of HIV. Doing so is necessary to assure that the law, as written, keeps up with scientific developments. Consider, for example, the advent of protease inhibitors and their miraculous impact on the lives of persons with HIV-disease. By the nature of this scientific development, many persons once living with a death sentence now have hope. The First Circuit's opinion is predicated, in part, on the notion that Ms. Abbott could not reproduce; the court reached that determination based on a broad definition of reproduction, including that Ms. Abbott would not be alive long enough to mother a child.[8] The First Circuit purposefully limited its opinion to the facts of the case, recognizing that scientific developments might change how it resolved future cases.[9] The question must be asked: with the benefits of protease inhibitors, would a similarly situated woman prevail in the First Circuit today? The application of a *per se* rule would not allow this or other important questions to be asked, let alone answered. This Court should accept the portion of the Petition related to the "disability" definition, if only to establish that the law can adjust to such developments.

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[8] Abbott v. Bragdon, 107 F.3d 934, 939-41 (1st Cir. 1997).

[9] Id. at 948. While the First Circuit left the door open for consideration of different facts, including those based on scientific developments, its decision, including by its construction of the Act's legislative history, still comes dangerously close to the application of a disability *per se* rule for HIV-disease.

CONCLUSION

The American Dental Association urges this Court to accept Dr. Randon Bragdon's Petition for Writ of Certiorari in order to address the "disability" issues offered for review. The Association believes resolution by this Court of the "reproduction" and "*per se*" issues are of paramount importance, in order to resolve a split in the circuit courts and to provide clear guidance to health care practitioners about their obligations to treat individuals with asymptomatic HIV-disease under the Americans with Disabilities Act, where those individuals claim "disability" status solely by virtue of an asserted inability to reproduce. The Association has endeavored to facilitate the educational purposes of the Americans with Disabilities Act by informing America's dentists and the patients they serve about their rights and obligations under the Act, and the safety of the dental office. We urge the Court to resolve the circuit split and provide clear guidance to our members.

Respectfully Submitted,

Peter M. Sfikas, Esq.
Counsel of Record
Mark S. Rubin, Esq.
Jill A. Wolowitz, Esq.
AMERICAN DENTAL ASSOCIATION
211 East Chicago Avenue
Chicago, IL 60611

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

JOINT APPENDIX

JOHN W. McCARTHY*
BRENT A. SINGER, Ph.D.
Rudman & Winchell, LLC
P.O. Box 1401
Bangor, Maine 04402-1401
Telephone: (207) 947-4501
Counsel for Petitioner

BENNETT H. KLEIN*
Gay & Lesbian Advocates & Defenders
294 Washington Street, Suite 740
Boston, Massachusetts 02108-4608
Counsel for Sidney Abbott

*Counsel of Record

PETITION FOR CERTIORARI FILED JULY 21, 1997
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RELEVANT DOCKET ENTRIES

DATE PROCEEDINGS

U. S. DISTRICT COURT
DISTRICT OF MAINE
Civil Docket No. 94-CV-273

12/01/94 Complaint filed

04/06/95 Amended complaint by Sidney Abbott

04/11/95 Answer by Randon Bragdon to amended complaint; jury demand

04/24/95 Order granting motion to intervene by USA, granting motion for leave to file amicus curiae brief; USA to file brief on same scheduling order as plaintiff (signed by Judge Morton A. Brody)

04/24/95 Intervenor's complaint by Maine Human Rights Commission against Randon Bragdon

05/10/95 Answer to intervenor, Maine Human Rights complaint by Randon Bragdon; jury demand

09/19/95 Motion by USA for summary judgment on constitutional issues re ADA

09/19/95 Statement of material fact by USA

09/19/95 Motion by Maine Human Rights Commission for summary judgment

09/19/95 Statement of material fact by Maine Human Rights Commission

09/19/95 Motion by Randon Bragdon for summary judgment under the ADA and MHRA

09/19/95 Statement of material fact by Randon Bragdon

09/19/95 Motion by Sidney Abbott for summary judgment

09/19/95 Motion by Sidney Abbott in limine to exclude expert report and testimony of Randon Bragdon

09/20/95 Motion by Randon Bragdon for summary judgment on intervening plaintiff Maine Human Rights Commission's complaint

10/06/95 Response by Randon Bragdon to motion for summary judgment

10/19/95 Reply by USA to response to motion for summary judgment on constitutional issues re ADA

10/19/95 Reply by Sidney Abbott to response to motion for summary judgment

10/19/95 Reply by Randon Bragdon to response to motion for summary judgment

10/20/95 Reply by Maine Human Rights Commission to response to motion for summary judgment

10/20/95 Response by Randon Bragdon to motion in limine to exclude expert report and testimony of Randon Bragdon

10/30/95 Reply by Sidney Abbott to response to motion in limine to exclude expert report and testimony of Randon Bragdon

12/22/95 Memorandum of Decision denying motion for summary judgment on intervening plaintiff Maine Human Rights Commission's complaint, granting motion for summary judgment, denying motion for summary judgment under ADA and on grounds that Congress lacks authority to regulate, denying motion for summary judgment under the ADA and MHRA, granting motion for summary judgment on

constitutional issues re ADA (signed by Judge Morton A. Brody)

02/20/96 Motion by Randon Bragdon to vacate injunction order

03/08/96 Response by USA to motion to vacate injunction order

03/08/96 Response by Sidney Abbott to motion to vacate injunction order

03/08/96 Response by Maine Human Rights Commission to motion to vacate injunction order

03/18/96 Reply by Randon Bragdon to response to motion to vacate injunction order

03/18/96 Second 60(b) motion by Randon Bragdon to vacate/relief from order

04/01/96 Response by Maine Human Rights to motion to vacate/relief from order

04/01/96 Response by Sidney Abbott to motion to vacate/relief from order

04/02/96 Response by USA to motion to vacate/relief from order

04/08/96 Reply by Randon Bragdon to response to motion to vacate/relief from order

04/22/96 Order denying motion to vacate/relief from order, denying motion to stay injunction until and pending appeal, denying motion to vacate injunction order, denying motion for further injunctive relief, denying motion for further injunctive relief (signed by Judge Morton A. Brody)

04/22/96 Judgment for Sidney Abbott against Randon Bragdon signed by Morton A. Brody, U.S. District Judge

05/10/96 Notice of Appeal by Randon Bragdon

FIRST CIRCUIT COURT OF APPEALS
Docket No. 96-1643
Appeal from U. S. District Court for the
District of Maine

06/12/96 Civil case docketed

03/05/97 Judgment: Terminated on the merits after oral hearing; affirmed; written, signed, published

03/19/97 Petition for rehearing and for in banc consideration

04/22/97 Order: by Judge Bailey Aldrich, Judge Bruce M. Selya, Judge Michael Boudin, Judge Norman H. Stahl, Judge Sandra L. Lynch. The petition for rehearing and the suggestion of rehearing en banc is denied. (Chief Judge Torruella, dissenting)

SUPREME COURT OF THE UNITED STATES
Docket No. 97-156
October Term, 1997

07/21/97 Petition for Writ of Certiorari filed

11/26/97 Certiorari Granted as to Questions 1, 2, and 3

AMENDED COMPLAINT AND INJUNCTIVE RELIEF SOUGHT

[U. S. DISTRICT COURT
DISTRICT OF MAINE]

[ABBOTT V. BRAGDON]

[Filed 04/06/95]

[Caption Omitted in Printing]

1. This action is brought pursuant to Title III of the American with Disabilities Act (ADA) and Title 5 Sections 4592 and 4621 of the Maine Human Rights Act (MHRA) against Randon Bragdon, D.M.D. ("Defendant Bragdon") to enjoin Defendant Bragdon's policy and practice of refusing to provide dental treatment and services to persons who are HIV-positive or have AIDS.

2. This Court has jurisdiction over Count I of this action under 42 U.S.C. Section 12188 and 28 U.S.C. Section 1331 and over Count II of this action pursuant to 28 U.S.C. Section 1367.

3. Plaintiff Sidney Abbott ("Ms. Abbott") lives in Brewer, Maine, and is an individual who has tested positive for the Human Immunodeficiency Virus (HIV). Ms. Abbott is, therefore, an individual with a disability within the meaning of the ADA, 42 U.S.C. Section 12102(2), and the MHRA, 5 M.R.S.A. Section 4553(7-A).

4. Defendant Bragdon is a dentist who is licensed to practice in the State of Maine. Defendant Bragdon's dental practice, which offers dental services to the general public, is owned by Defendant Bragdon. Defendant Bragdon is a person who owns and operates the professional office of a health care provider, the operations of which affect commerce. Accordingly, Defendant Bragdon is subject to Title III of the American with Disabilities Act. 42 U.S.C. Section Sections [sic] 12181(7)(F) and 12182. In addition, Defendant Bragdon's dental office is a "place of public accommodation" as defined in

5 M.R.S.A. Section 4553(8).

5. On September 16, 1994, Ms. Abbott sought dental care from Defendant Bragdon. On that date, Ms. Abbott went to Defendant Bragdon's office at 30 Judson Boulevard in Bangor, Maine (the "Office") for a previously scheduled dental appointment.

6. At the Office, Defendant Bragdon's staff asked Ms. Abbott to fill out a medical questionnaire which asked whether Ms. Abbott was HIV-positive or had AIDS. In response to the question, Ms. Abbott answered that she was HIV-positive.

7. Ms. Abbott entered Defendant Bragdon's treatment room. Defendant Bragdon performed a quick dental examination of Ms. Abbot and indicated that she had a cavity that needed to be filled.

8. Defendant Bragdon asked Ms. Abbott if she had any medical conditions.

9. In response to Defendant Bragdon's question, Ms. Abbott told Defendant that she was HIV-positive.

10. Defendant Bragdon refused to provide Ms. Abbott with dental treatment at his Office because of Ms. Abbott's HIV-positive status.

11. Defendant Bragdon has a written policy that he does not provide dental treatment to people with HIV or AIDS. A copy of Defendant Bragdon's policy is attached as Exhibit A to this Complaint.

12. Defendant Bragdon indicated to Ms. Abbott that he would provide dental treatment to Ms. Abbott, including filling her cavity, in a separate and different setting – a hospital surgical operatory. Defendant Bragdon also indicated that Ms. Abbott would have to pay the hospital's fee for the surgical operatory.

13. Upon information and belief, as of September 16, 1994, and the date of this Amended Complaint, Defendant Bragdon

has never had privileges to use the facilities of any hospital nor has he ever applied for such privileges.

14. If Ms. Abbott returns to Defendant Bragdon's office for further dental treatment or services, she will encounter the same discriminatory conduct which she experienced on September 16, 1994. Ms. Abbott would return to Defendant Bragdon's office for routine and regular dental treatment, including cleanings and fillings, if Defendant Bragdon offered dental services to HIV-positive persons on the same terms and conditions as he offers dental services to persons who are not HIV-positive.

COUNT I: VIOLATION OF TITLE III OF AMERICANS WITH DISABILITIES ACT

15. Ms. Abbott repeats the allegations contained n Paragraphs 1-14 of this Amended Complaint and incorporates them herein.

16. By denying Ms. Abbott dental treatment in his Office because of her HIV-positive status, and by adopting and implementing a policy of refusal to treat persons who have tested positive for HIV, Defendant Bragdon unlawfully discriminated against Ms. Abbott and has violated Title III of the ADA, including without limitation in the following ways:

A. Defendant Bragdon has denied to Ms. Abbott the opportunity to benefit from the services of a place of public accommodation, in violation of 42 U.S.C. Section 12182(b)(1)(A)(i).

B. Defendant Bragdon has imposed eligibility criteria, for the privilege or advantage or receiving dental services, that screen out the class of persons who have tested positive for HIV, in violation of 42 U.S.C. Section 12182(b)(2)(A)(i).

C. Defendant Bragdon has failed to make reasonable modifications in policies, practices or procedures where such modification is necessary to afford equal advantages or privileges to the class of persons who have tested positive for HIV, in violation of 42 U.S.C. Section 12182(b)(2)(A)(ii).

D. Defendant Bragdon has a practice and policy which provides different and separate dental treatment to individuals who are HIV-positive in violation of 42 U.S.C. Section 12182(b)(1)(A)(iii).

E. By refusing to provide dental services in his Office to HIV-positive individuals, Defendant Bragdon has failed to provide the goods, services, facilities and advantages of a place of public accommodation in the most integrated setting appropriate to the needs of HIV-positive persons, in violation of 42 U.S.C. Section 12182(b)(1)(B).

COUNT II: VIOLATION OF MAINE HUMAN RIGHTS ACT

17. Ms. Abbott repeats the allegations contained in Paragraphs 1-16 of this Amended Complaint and incorporates them herein.

18. On September 21, 1994, Ms. Abbott filed a Complaint with the Maine Human Rights Commission (the "Commission") which alleged that she was denied dental treatment by Defendant Bragdon in a place of public accommodation because she is HIV-positive in violation of the MHRA.

19. By letter dated February 17, 1995, the Commission informed Ms. Abbott and Defendant Bragdon that it had determined that there are reasonable grounds to believe that unlawful discrimination under the MHRA had occurred. The Commission has failed in its efforts to enter into a conciliation agreement with Ms. Abbott and Defendant Bragdon.

20. By denying Ms. Abbott dental treatment because she is HIV-positive, establishing eligibility criteria for treatment which screen out persons with HIV or AIDS, and by providing different, separate and unequal dental services to individuals who are HIV-positive, Defendant Bragdon has violated 5 M.R.S.A. Section 4591 and 4592.

REQUEST FOR RELIEF

WHEREFORE Plaintiff Sidney Abbott requests that the Court:

A. Declare that the discriminatory practices of Defendant Bragdon, as set forth above, discriminate against persons who have tested positive for HIV, in violation of Title III of the Americans with Disabilities Act and Title 5 of the Maine Human Rights Act;

B. Enjoin Defendant Bragdon, his agents and employees, and all other persons in active concert or participation with any of them, from refusing to provide treatment to persons who have tested positive for HIV on the same terms and conditions as patients who have not tested positive for HIV;

C. Order that Defendant Bragdon post a sign in a conspicuous location in his office visible to all patients who enter his office for treatment that: "Randon Bragdon, D.M.D. does not discriminate against persons who have tested positive for the Human Immunodeficiency Virus (HIV) or who have AIDS. Randon Bragdon, D.M.D. provides dental treatment and services to people with HIV or AIDS on the same terms and conditions as are provided to patients who are not HIV-positive;"

D. Award Ms. Abbott her attorneys' fees and costs, including expert witness fees and costs;

E. Award Ms. Abbott civil penal damages in the amount of $10,000 in accordance with 5 M.R.S.A. Section 4613(2)(B)(7); and

F. Order such other appropriate relief as the interests of justice may require.

/s/ Bennett H. Klein, Esq.
/s/ David G. Webbert, Esq.

DEPOSITION OF SIDNEY ABBOTT
DATED MAY 16, 1995

[Filed September 19, 1995
D.C. Me.]

[Caption omitted in printing]

***

[Page 14]

Q. As I understand it, you're HIV positive; is that right:

A. Yes.

Q. Do you distinguish that term describing your condition from suffering from AIDS?

A. I don't have AIDS.

Q. You're just HIV positive?

A. Correct.

Q. And how long have you known you were HIV positive?

A. Nine years.

Q. And has there been any change in your condition during that nine years?

A. No.

Q. And has there been any change or ever any suggestion that you weren't HIV positive during that ten years – nine or ten years?

A. No.

Q. Are you presently under the care of some physician or group or health care provider for this condition?

A. Yes, Dr. Rob Pinsky.

[Page 15]

Q. Did you say Rod?

A. Rob. R-o-b.

Q. What kind of a doctor is Dr. Pinsky?

A. I believe he's an immunologist.

Q. And where is he located?

A. At Eastern Maine Medical Center.

Q. And are you under the care of anybody else for the condition of being HIV positive except for Dr. Pinsky?

A. No.

Q. How often do you see Dr. Pinsky?

A. Every six months.

Q. So you've seen him 15 or 18 times over the last nine years?

A. Yeah.

Q. Has he been your health care provider –

A. Oh, no. no. I've seen him --. I've had other care providers. I had Dr. Jeff Milliken before that.

Q. Where is he located?

A. Blue Hill.

Q. How far back does Dr. Pinsky's treatment go?

A. I believe it's been two years.

Q. And for how – Dr. Milliken was immediately before him?

A. Correct.

Q. And for how long did Dr. Milliken treat you?

A. About two years.

[Page 16]

Q. Why did you change?

MR. WEBBERT: I'm going to object to any questions that go into her medical history, besides the doctors involved, because of her right of privacy in that area.

I'm going to object on the grounds of privilege to any details of her medical treatment other than the fact that she's HIV positive.

***

[Page 17]

MR. GILBERT: I take it it's your position that by bringing this suit, she has not put her medical condition in issue?

MR. WEBBERT: She's put her HIV status in issue, but not anything else.

And as I understand it, it's undisputed that the defendant has a blanket policy of not treating anyone who's HIV positive, regardless of any other details about the nature of the condition.

So not only does she have a privilege, but it's irrelevant to the case, which I think makes it even more obvious that there should be no question on the subject matter.

***

[Page 18]

MR. GILBERT: Just so we're clear on this, you're taking the position that we're not entitled to inquire or obtain discovery that confirms her now sworn assertion that she's HIV positive, but has not progressed to full-blown AIDS?

MR. WEBBERT: We think the issue of whether she's HIV

[Page 19]

positive, she's provided information on that to verify that. But other than that, her medical condition is not in controversy in this case.

MR. MCCARTHY: We disagree.

MR. WEBBERT: Sure.

MR. MCCARTHY: Is there something –

MR. WEBBERT: I'm just telling you I'm going to instruct her not to answer. If that helps move along the deposition, I just wanted to tell you now instead of making it seem confusing to you as to why I was instructing her not to answer.

BY MR. MCCARTHY:

Q. Is there something unusual in your medical background?

A. My lawyer has asked me not to answer anything about my medical background.

***

[Page 24]

Q. Is there a prognosis --. Have you been given a prognosis for your condition of being HIV positive?

MR. WEBBERT: Same objection.

MR. GILBERT: That calls for a yes or no answer.

MR. WEBBERT: Objection, and I instruct you not to answer.

BY MR. MCCARTHY:

Q. As a result of being – or strike that.

Are you impaired in your ability to carry out any of your life functions by the fact that you are HIV positive?

A. No.

Q. And are you impaired in carrying out any of the ordinary functions of life and your life functions by any other condition other than being HIV positive?

A. No.

***

[Page 79]

EXAMINATION

BY MR. WEBBERT:

Q. I have a couple questions. How, if at all, has your HIV status affected your life activity with respect to getting pregnant?

A. I have made the decision after I tested positive not to have children because of the risk of infecting the child and the risk of impairing my own immune system, and also the fact that this baby probably wouldn't have a mother after a while.

Q. How, if at all, has your HIV positive status affected your life activities with respect to seeking employment in the educational field?

A. I made a decision not to seek employment in the

education field because of the stress level involved with teaching. And I chose to remain in my current line of work because it's not as stressful as teaching.

MR. WEBBERT: That's all I have. Any other questions?

MR. CARNES: The Commission has no questions.

MR. McCARTHY: Let me just think for a minute.

MR. WEBBERT: Sure.

MR. McCARTHY: No, I don't have any questions.

***

DEPOSITION OF RANDON BRAGDON, D.M.D.
TAKEN ON JUNE 5, 1995

[Filed September 19, 1995
D.C. Me.]

[Caption Omitted in Printing]

(Page 3)

BY MR. BENNETT KLEIN:

Q. Could you please state your full name for the record?
A. Randon Alvin Bragdon.
Q. Have you ever been deposed before?

(Page 4)

A. Yes, I have.
Q. How many times?
A. Three times.
Q. Would you identify those three times that you have been deposed?
A. The two times that you have deposed me previously and one time involving a timber theft case.
Q. Can you indicate the last deposition?
A. It was a case involved timber theft.

MR. McCARTHY: Timber.

BY MR. KLEIN:

Q. Were you a party to the case of timber theft?
A. Yes.
Q. And were you the plaintiff?
A. No.
Q. What was the plaintiff's name?
A. Mylon Davis.
Q. And I take it you were the defendant in the case?
A. Yes.
Q. When was the case – in what court was the case filed?
A. In, I think Superior Court here.
Q. In Penobscot County?
A. Yes.

Q. Do you know what year the case was filed in?

***

(Page 241)

A. I would tell them my policy. If they wanted to be treated, I would treat them in the hospital operatory.
Q. Where would you treat them?
A. That is a question now because originally I had thought last year that Eastern Maine still had an adequate facility; but they have since – as I understand it now, they have allowed that to deteriorate and it is not adequate.
Q. Assuming that a patient with infectious hepatitis B presented at your office with an avulsed tooth that needed to be reimplanted, what steps would you take to implement your infectious disease policy?
A. Now, are you saying known antigen positive?
Q. Yes.
A. I would refer him to an oral surgeon.
Q. Why?
A. Because I would feel that he would be better capable of handling it there.
Q. Why is that?
A. Because they feel comfortable handling those.
Q. Do you – have you ever reattached – reimplanted an avulsed tooth?
A. Yes.

(Page 242)

Q. Assuming that a patient arrived at your office needing a cavity filled and indicated that he was HIV positive, what steps would you take to implement your infectious disease policy under those circumstances?
A. I would tell them that I would be glad to treat him in a hospital environment.
Q. Okay. Where would you treat them?

A. I'm not sure. I would have to find out now.
Q. Assuming that a patient who was HIV positive presented at your office with an avulsed tooth that needed to be reimplanted, what steps would you take to implement your infectious disease policy?
A. I would refer him to one of the oral surgeons.
Q. Why would you do that?
A. Because he could treat them.
Q. How many times have you reimplanted an avulsed tooth?
A. It's not a frequent thing. Maybe once every two years.
Q. Okay. And is that a dental procedure that you consider to be generally within the realm of your training?
A. Yes.

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Q. Okay. And competence?
A. In some situations, yes.
Q. Okay. Describe to me why an oral surgeon is more suitable for reimplanting an avulsed tooth in a situation where you would otherwise ordinarily do that.

MR. GILBERT: Are you talking hypothetically, strictly hypothetically?

MR. KLEIN: I'm talking about the situation I have just presented to him.

MR. GILBERT: Well, if hypothetically he could immediately take the patient into a hospital operatory and we didn't have this other issue as to whether he could immediately go in, are you asking him to include or exclude that in the assumption?

BY MR. KLEIN:
Q. Dr. Bragdon, you indicated that if a patient presented with HIV, who was HIV positive and needed an emergency reimplanting of an avulsed tooth, you would refer that patient to an oral surgeon, is that correct?

A. Yes.
Q. And what I am asking you is what concerns of yours – or why would you refer the patient to an

(Page 244)

oral surgeon?
A. Because they have hospital privileges, and they could take them to the hospital without any difficulty, although you do need to realize that I can take any patient on an emergency basis to a hospital.
Q. What hospital?
A. Any hospital.
Q. With respect to the patient that we are talking about presenting with HIV who has an avulsed tooth that needs reimplanting, what hospital would you take him to?
A. I'm not sure at this time. I would have to check to see what the available facilities were.
Q. Are there any conditions other than HIV which you would only treat in a hospital setting?

MR. GILBERT: Object to the form of that question. I don't think there has been any evidence that he has ever undertaken to treat HIV, period.

BY MR. KLEIN:
Q. Let me ask this question: Are there any circumstances under which you would treat a patient you knew to be HIV positive in your private dental office?

(Page 245)

A. You mean outside of an exam and diagnosis?
Q. Is that treatment?
A. I don't know what you mean.
Q. Do you provide dental treatment – under the infectious disease policy, do you provide dental treatment to patients who are HIV positive in your private dental office?
A. No.

Q. Okay. Are there any circumstances under which you would provide dental treatment to patients who you know to be HIV positive in your private dental office?
A. By dental treatment if you mean invasive procedures, no.
Q. Are there any infectious diseases or conditions other than HIV which under your infectious disease policy – strike that. Let me go back.
Under your infectious disease policy, are you willing to treat an HIV-positive patient in a hospital?
A. Yes.
Q. Okay. Are there any conditions other than HIV which you would treat in a hospital setting?
A. Yes. The infectious diseases that are listed here.

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Q. All of them?
A. Yes.
Q. Does that include strep throat?
A. Yes.
Q. So you would treat a patient who is infectious with strep throat in a hospital setting?
A. Yes, I would.
Q. Is that true also of measles?
A. Yes, although you would have to advise them so that if they had any personnel that had not had measles that there wouldn't be – there would no no contact with them.
Q. If who had any personnel?
A. You would have to advise the hospital that you was coming in with somebody with measles so that they could make arrangements so that there wouldn't be any hospital personnel that would have direct contact with them. This would be – again, we are talking in the case of measles an emergency because normally you would wait until the disease had abated and resolved itself.
MR. KLEIN: Can we take a five-minute

break?
MR. McCARTHY: Sure.
(Recess taken from 10:50 to 11:02.)

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BY MR. KLEIN:
Q. Dr. Bragdon, can you tell me why you're willing to treat HIV-positive patients in a hospital?
A. I believe it's the safest setting and also, as I said before, I think that additional measures can be implemented there which aren't practical in a private office.
Q. Can you describe your standard procedure in your office when a new patient comes for their first visit?
A. They are given a form for their medical and dental history, asked to fill that out; and then depending on the situation, either just before they come in or when they come in, I review that history and then do an interview with them..
Q. What kinds of questions do you ask in the interview?
A. If there is anything that I have noted on the medical or dental history that I would like to have further clarified, I will ask them about that.
Q. Anything else?
A. I will ask them what was their purpose of coming in and then get, depending on what their purpose was, a brief history or do an exam right then or

(Page 248)

get a brief history and then take a look.
Q. Are there any other questions which you routinely ask each patient or most patients?
A. That's pretty much it.
Q. Assuming that you have a new patient, is there anything that you would do for each patient in terms of the general dental exam assuming it is a patient you had not ever treated before?

A. It depends on what they want to have done. For example, if they have a tooth that is abscessed and they want to extract it, then we would take and do an X-ray, examine the tooth and just take a quick look in their mouth because they haven't asked for, and we wouldn't charge them for, the complete exam.
Q. Assuming that a patient presented with tooth pain, what steps would you take?
A. Depends on what kind of pain they are having.
Q. Well, what are the different things you might do under the different kinds of tooth pain that people present with?
A. Different things would be they may need just – sometimes you can look at it and just touch it and be able to identify the tooth that is bothering. Sometimes you need percussion where

(Page 249)

you tap on the teeth. Sometimes we use ice to determine which teeth are involved, do an examination with a mirror and explorer, may take a periapical X-ray or we might take an extraoral X-ray depending on the situation.
Q. Can you tell me what both those procedures involve, a periapical X-ray?
A. It involves using the – either an intraoral X-ray unit or an extraoral X-ray unit and taking a radiograph.
Q. Okay. Anything else?
A. We are talking strictly tooth pain?
Q. Yes.
A. Sometimes you might check for a cracked tooth.
Q. How do you do that?
A. You take and sometimes tap on different cusps in succession, press outward from the center of the tooth on the various cusps. We also have an instrument we call a bite checker which has kind of a cup point on it, which we have them bite down on different cusps and in the center and see if we elicit responses indicative of a cracked

tooth or not.
Q. Okay. Can tooth pain ever be indicative of related dental issues?

(Page 250)

A. What do you mean by related dental issues?
Q. Is tooth pain ever indicative of other – of the existence of other dental conditions that need treatment?
A. I don't understand the question.
Q. Okay. When a patient presents with tooth pain, can that be a symptom of some other underlying dental problem that may need treatment?
A. I still don't really understand the question. Do you mean outside of the tooth structure itself?
Q. Well, if a patient presents with tooth pain, could that, for example, be indicative of a cavity?
A. Yes.
Q. Okay. And if a patient presents with tooth pain, could that be indicative of other problems or dental needs aside from a cavity?
A. Now, you're asking – this hypothetical patient has come, which I have never seen before –
Q. And complains of tooth pain.
A. And complains of tooth pain.
Q. Right.
A. And upon examination I note that tooth has a cavity.
Q. Right.

(Page 251)

A. And now you are asking me can the pain be due to something else besides the cavity?
Q. Yes.
A. Yes.
Q. Okay. What other kinds of dental problems could tooth pain be indicative of other than a cavity?
A. It could be a sinus infection.
Q. What else?

A. It could be a periapical abscess.
Q. I'm sorry?
A. It could be a periapical abscess.
Q. What else?
A. There could be an abscess in either the pulp chamber or one of the root canals.
Q. Okay. Anything else?
A. There could be a lateral cyst. There could be an interradicular cyst between the roots.
Q. Can you spell that?
A. I-N-T-E-R-R-A-D-I-C-U-L-A-R cyst. It could be a periapical lesion. It could be a cyst or a granuloma. I have had one or two patients that had mestatasized cancer.
Q. Anything else?
A. It could be root fracture. It could be referred pain from another tooth that appears on

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the area of that tooth. Occasionally we get a patient that has got an infection that is either mid face or in the nasal cavities that will kind of settle down in this area here and they will –
Q. You have to say which area so the court reporter –
A. Settle in the inframandibular area.
Q. Where is that in layperson's terms?
A. Along the edge of the lower jaw.
MR. McCARTHY: Right here.
A. And they will sometimes think that this is tooth pain. We have to make that distinction.
BY MR. KLEIN:
Q. Anything else?
A. Once in a great while there is a piece of a primary or baby tooth that has been retained. Sometimes when a patient has lost their baby tooth, a piece of it will remain behind, especially sometimes the root. It's not real frequent, but sometimes a piece of root will eventually work it's way out; and they will be getting some pain from that. If it's between the

teeth, it's hard to see. Sometimes there is another cavity in the tooth that is actually causing the pain besides the one that is readily ....

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Q. Prior to 1991, prior to the changes you made on the form in 1991, how many different versions of your Patient's Registration and Health Record did you use during the course of your practice of dentistry beginning in 1978?
A. Two, maybe three. I can't remember exactly.
Q. Do you recall the first time that you changed your patient's registration form subsequent to 1978?
A. No.
Q. Do you have any approximation of when that was?
A. I really can't remember.
Q. But to the best of your understanding, you modified your patient registration form two or three times between 1978 and up to the time you made these changes in 1991?
A. You have worded that a little different. Before 1991, we've had two to three other forms.
Q. Okay. Prior to 1991 did you ask patients any questions about the existence of AIS, HIV, autoimmune Disease or Immune Deficiency Disease?
A. I can't remember for sure if autoimmune was in there, but we didn't have AIDS or HIV positive on it.
Q. Prior to 1991 before you treated each patient,

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did you ask them if they were HIV positive?
A. No.
Q. Did you ask – prior to 1991 before you treated each patient, did you ask them if they had AIDS?
A. No.
Q. Do you have in your office forms in patient

records that are on the pre-1991 Patient Registration and Health Record forms?
A. We have them filled out, yes.
Q. Yes, okay.
MR. KLEIN: And, John, what I would ask since I do think that is responsive to our document request in terms of all patient history forms is that you produce to us all of the different versions with all information redacted, just the form itself essentially.
A. We could do that.
Q. Thank you.
(Bragdon Exhibit 11-B marked.)
BY MR. KLEIN:
Q. Can you identify Exhibit 11-B?
A. This is the front and back side of my Patient Registration and Health Update.
Q. When was this form written?
A. This would have been in 1991.

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Q. Did you have a patient registration and health update prior to 1991?
A. No.
Q. Is it correct, then, that prior to 1991 the only medical questionnaire or form that a patient filled out was the Patient Registration and Health Record, is that right?
A. Yes.
Q. And was the Patient Registration and Health Record filled out at the time of the patient's first visit to your office?
A. Yes, it was.
Q. Okay. Prior to 1991 when patients came in for visits after their first visit, did you review the Patient's Registration and Health Record with the patient on each occasion?
A. We have a sign that asks them to let us know if there has been any change in their health or medications, and also I generally ask them how they have been and how they are doing.

Q. Other than that did you seek any medical information from patients who were not new patients prior to 1991?
A. Those were the methods we used to update.
Q. Would you tell me everything that you can recall

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about Sidney Abbott's contact with your office?
A. What contact?
Q. Has Sidney Abbott had any contact with your dental office?
A. She made an appointment, which I don't know anything that was involved with that, and then she came in, filled out her registration and health record. I looked at her registration and health record, noted that she had checked HIV positive. She was seated. I asked her if she had any medical problems. She said she was HIV positive, and I asked her what I could do for her. She said she had been to another office and they had advised her that she had a cavity after doing an examination, which she pointed to, and she wanted to know how much it would be for me to restore that cavity; and I told her that I had an infectious disease policy and we didn't treat infectious patients in the office, that I would be happy to treat her in the hospital setting and that the fee would be my regular fee plus whatever the hospital charge was; and she said that she would think about it and get back to me and let me know what she decided. And on the way out she asked if there was any fee, and I said, ...

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A. We use single gloves when we do examinations.
Q. Okay. Did Judith Bragdon ask you anything else?
A. No.
Q. Did you have any conversations with anyone else

in your office on September 16th, 1994, about Sidney Abbott prior to meeting Sidney Abbott?
A. No.
Q. Tell me what happened when Sidney Abbott entered your treatment room. What was the first thing you said to her?
A. I can't remember. Probably small talk. Usually I comment on the weather or something like that, but I can't remember.
Q. Prior to Sidney Abbott's entering your treatment room, had you determined in your own mind whether you would provide dental treatment to her or not?
A. I didn't know what she wanted done.
Q. Prior to Sidney Abbott's entering your treatment room – well, by dental treatment, how do you define dental treatment?
A. I don't understand the question.
Q. Okay. Let me step back and rephrase that. Prior to entering – Sidney Abbott entering your treatment room, had you made any determination about whether you would provide a service to her

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such as filling a cavity?
A. Not specific to her, no.
Q. Okay. Prior to meeting Sidney Abbott, did her HIV status – her HIV-positive status – had you made any decision about what you would and wouldn't provide to her on September 16th, 1994, on the basis of her HIV-positive status?
MR. GILBERT: Are you focusing the witness's attention on the approximately one-minute time frame that he talked about earlier between when he reviewed the form and when he showed the patient into the office, in that one minute?
MR. KLEIN: Right.
BY MR. KLEIN:
Q. Prior to meeting Sidney Abbott.
A. No.
Q. Okay. Describe to me everything you can remember

about what Sidney Abbott said to you and what you said to her.
A. I think I already have.
Q. Okay. Is there anything else?
A. Not that I can recollect right now.
Q. Okay. What – did you take – tell me what type of dental examination or procedures you performed

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on Sidney Abbott?
A. She said – I examined the lesion which she was inquiring about, and then I did a general exam.
Q. Okay. And what does that consist of specifically?
A. Basically, it's a general look at the soft tissue and a general look at the other teeth to see if there is any major problems.
Q. Okay. What instrument –
A. With the mirror and explorer.
Q. I'm sorry?
A. A mirror and an explorer.
Q. Tell me exactly what you did with a mirror and explorer?
A. What do you mean?
Q. How did you use them to perform the dental exam?
A. Took the mirror in my left hand and the explorer in my right hand and examined the teeth. I may have used the mirror to retract her cheek, too. I sometimes do during an exam.
Q. And you noticed on the health registration form that Ms. Abbott indicated that she had a toothache?
A. Yes.
Q. And did you take any steps to determine whether

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Ms. Abbott's toothache was indicative of something other than a cavity such as the – such as the dental conditions which you described earlier that can be – that a toothache would be

indicative of?

A. No, because I did ask her if it was bothering her, and she said no. She said that she had been recently examined by another dentist.

MR. KLEIN: Can we have this as the next exhibit?

(Bragdon Exhibit #14 marked.)

BY MR. KLEIN:

Q. Can you identify Exhibit 14?

A. Yes. This is the record of Sidney Abbott with the front and back page.

Q. Can you please read into the record all of the notations that you placed on that record?

A. "9/16/94, buckle decay, number 18. HIV diagnosed eight years ago. Wants to know cost. 35 to 45 dollars. Would have to do in hospital outpatient because of infectious disease policy. Will think about and get back to us." And it's noted under the charges, no charge.

Q. If Sidney Abbott had not indicated on the Patient Registration and Health Record that she is HIV ....

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Q. Describe to me the circumstances under which you would have filled Sidney Abbott's cavity.

A. If she had indicated that she wanted to have it done, I would have made arrangements, if possible, to do it in a hospital setting.

Q. What hospital?

A. I'm not sure.

Q. Why aren't you sure?

A. Because I've never had to take and make arrangements for such a thing.

Q. What hospital would you have attempted to treat Sidney Abbott in?

A. Probably Downeast Memorial Hospital.

Q. Where is that?

A. In Machias. Did I say Downeast Community Hospital?

Q. That's in Machias?

A. Yes.

Q. How many miles is Machias from Bangor?

A. I'm not sure.

Q. Do you have an estimate?

A. Probably 60 miles or thereabouts.

Q. Are there any other hospitals aside from Machias that you would have considered treating Sidney Abbott in?

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A. I would have considered Eastern Maine or St. Joseph's Hospital.

Q. Any others?

A. No.

Q. Where is St. Joseph's Hospital located?

A. In Bangor.

Q. As of September 16th, 1994, you did have privileges at – to use the facilities of any hospital, is that correct?

A. That is correct.

Q. And prior to September 16th, 1994, had you ever inquired about obtaining privileges at any hospital?

A. No.

Q. And had you ever even inquired about the process for obtaining privileges at any hospital prior to September 16th, 1994?

A. No.

Q. Okay. At some time subsequent to September 16th, 1994, did you have any communication with the Eastern Maine Medical Center?

A. No.

Q. Okay. At some time subsequent to September 16th, 1994 – strike that. On September 16th, 1994, if Ms. Abbott had wanted you to fill her cavity, was

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Eastern Maine Medical Center the first place that you would have inquired into with respect to

using a hospital operatory?
A. Yes.
Q. All right. And at some time after September 16th, 1994, did you learn anything about Eastern Maine Medical Center that would affect your ability to obtain privileges there to use a dental operatory?
A. Yes.
Q. What did you learn?
A. I learned that you were planning to depose Dr. Paul LaMarche.
Q. When did you learn that?
A. From my counsel, John McCarthy.
Q. When did you learn that?
A. I can't remember for sure.
Q. Continue.
A. And that flagged us that there must be some problem at Eastern Maine which you planned to amplify on. So with that I called Dr. Chris Maller.
Q. Can you spell the last name?
A. M-A-L-L-E-R.
Q. Okay. Was that prior to LaMarche's deposition?

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A. Yes.
Q. And who is Dr. Maller?
A. He is a general dentist in Bar Harbor who also has an office up here.
Q. In Bangor?
A. Yes. I knew he did some hospital dentistry, and at the time I thought he was in the Eastern Maine facility. So I was going to inquire about their facilities and application and whatnot. He advised me that the head of dental services at Eastern Maine was also the head of dental services at St. Joseph's Hospital. It was a problem in that he was against general dentists working in a hospital setting.
Q. Who is the head of dental services at Eastern Maine Medical Center that you are referring to?

A. Dr. Daniel McCarthy.
Q. What else did Dr. Maller tell you?
A. He told me that as a result he couldn't make any headway with getting hospital privileges at Eastern Maine, and he understood that they had allowed the dental facility to deteriorate.
Q. Did he tell you specifically how they – did he tell you specifically or – did he tell you specifically what kind of dental facility they ....

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A. He is a general dentist –
Q. Okay.
A. -- who is head of dental services down there.
Q. How did you get Dr. Dorr's name?
A. I knew him. I knew he was doing hospital dentistry down there.
Q. All right. How did you know that?
A. Previous conversations.
Q. What was your conversation with Dr. Dorr?
A. I asked him about getting courtesy privileges, and his response was: Do you have an HIV patient that you want to treat? And I said I may have. And he indicated he didn't think there would be any problem with getting privileges and sent the application form out the next day.
Q. Okay. Did you first tell Dr. Dorr that you may have an HIV-positive patient?
A. No. He asked me.
Q. Okay. So you didn't mention – he asked you whether you had an HIV-positive patient that you wanted to treat prior to your mentioning anything about having an HIV-positive patient, is that right?
A. Let's back up a bit. I asked him about the hospital privileges, and that was his response

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because he is aware of my infectious disease policy.

Q. All right. Was Dr. Dorr at the time that you called him aware of the litigation in the case known as John Doe versus Randon Bragdon?

A. Yes, he was.

Q. How was he aware of that; do you know?

A. From the mailings.

Q. What mailings?

A. That I had mailed out to the members of the dental society in '91.

Q. Did those mailings reference the lawsuit brought by John Doe?

A. Yes.

Q. Had you prior to this conversation had any –

A. Let me think here a minute. It referenced the proceedings of the Maine Dental Society. It may not have been the lawsuit itself. I believe there had been an article or two in the paper, or three.

Q. Prior to your conversation with Dr. Dorr about obtaining privileges at Machias, had you ever had a discussion with him about your infectious disease policy?

A. No.

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Q. Okay. Had you ever had a discussion with him about the previous lawsuit against you brought by John Doe?

A. No.

Q. What else did you discuss with Dr. Dorr in this conversation?

A. That was it. That wasn't it. I asked him what they had for a facility there, if we would be able to do general dentistry, and he said yes.

Q. Tell me everything you know about the facilities for dentistry at Machias.

A. He said that they had a chair, delivery unit and a hospital operatory for it.

Q. Is that everything you would need?

A. It was the best I could find at the time.

Q. Well, is it everything you would need?

A. It's not everything I desire. It's the best we could do. That's why we have worked hard to get three state-of-the-art facilities here in the state because we recognize that what we need isn't available.

Q. What is your understanding of the infection control capabilities of the hospital operatory at Machias?

A. I haven't been down there to actually see it, so

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I would have to inspect it, but my understanding is that, one, we would be able to wash it down completely after use. I would be able to set up so that virtually everything that couldn't be autoclaved could be disposable.

Q. Anything else?

A. And they had a filtered-air system?

Q. What do you mean by a filtered-air system?

A. That the air would be filtered for airborne pathogens.

Q. Okay. Is that everything?

A. That's all I'm sure of or I feel sure of.

Q. Have you ever been to Machias to inspect their facilities?

A. No.

Q. Did you ever make any inquiry about the nature of the infection control capabilities of the facilities at Machias other than this conversation you are relating with Dr. Dorr?

A. No.

Q. If you had privileges to use the facilities at Machias on September 16, 1994, would you have treated Sidney Abbott in that facility?

A. Yes.

MR. GILBERT: You're assuming for ....

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report, you indicate that prior to receiving dental treatment in the hospital operatory the patient should have a monitoring of eye conditions, is that correct?

A. Yes.

Q. And what is the purpose of that?

A. To make sure that they are not having problems with HIV disease affecting their eyes.

Q. And how is monitoring of the eye conditions relevant to providing dental treatment to an HIV-positive person?

A. If you are treating a patient who has got a serious illness such as HIV, you do want to be assured that they are getting good medical care; and these are items that somebody who is getting good medical care should be getting.

Q. Are these numbers one through four prerequisites to your providing dental treatment to an HIV-positive patient?

MR. GILBERT: You're talking about paragraph four, subs one through four?

MR. KLEIN: That is correct. Thank you.

A. In consulting their physician, yes.

BY MR. KLEIN:

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Q. No. I am talking about Roman numerals one through four of paragraph four. Are those prerequisites to your providing dental treatment to a patient with HIV?

A. This is considered what an HIV patient should be getting for good medical care.

Q. And my question is are those tests prerequisites to your actually providing dental treatment to an HIV-positive patient?

MR. McCARTHY: Are you intending to separate those out from the paragraph up above which refers to the requirement of consultation

with a physician? These do not seem to be free standing. You can make them free standing, but I want to make sure you make that question clear to Dr. Bragdon if that is what you are doing.

MR. KLEIN: Well, yes. He is asking if those things have been done, I assume, as part of his medical evaluation.

Q. Is that right?

A. That's right.

Q. So my question to you is is number one – Roman numbers one through four of paragraph four prerequisites to your providing dental treatment to an HIV-positive patient?

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A. They are what is recommended for good routine medical care and follow-up on an HIV patient. I would be interested in whether or not they are getting that care.

Q. All right.

A. An individual physician may provide for one of these items in a different way. So, you know, it's not hard and fast, but we are certainly interested in whether or not they are being evaluated on a regular basis in pointed areas for the condition of HIV disease.

Q. All right. Is it your position that you will not treat a person with HIV who in your personal opinion is not receiving good medical care?

A. That's right.

Q. Do you have – have you ever treated any patient who is on cancer chemotherapy?

A. Yes.

Q. Have you ever treated any patient with diabetes?

A. Yes.

Q. Have you ever treated any patient with lupus?

A. I don't think so.

Q. Have you ever treated any patient with any other kind of immunodeficiency or immunosuppressed condition other than cancer chemotherapy and

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diabetes other than HIV?
A. I think we have one patient with bone marrow transplant.
Q. Anything else?
A. Did you say leukemia?
Q. No. Have you treated patients with leukemia?
A. Yes.
Q. Any other immunocompromised patients?
A. We have got diabetes. You have got diabetes?
Q. Yes, I do.
A. Hodgkin's disease. There may be one or two others, but that's what comes to mind now.
Q. With respect to patients for each of the immunocompromised conditions that you have just answered, tell me all medical evaluation that you obtain prior to providing dental treatment.
A. These patients are under the regular care of a physician.
Q. Is it accurate, then, that when patients have the immunocompromised conditions of chemotherapy, diabetes, bone marrow transplants, leukemia and Hodgkin's disease you do not require specific medical consultation and evaluating?
A. No, because I know they are under regular care. I do – if we have a specific question, I will ....

DEPOSITION OF RANDON BRAGDON, D.M.D.
TAKEN ON JUNE 13, 1995 AND JUNE 14, 1995

[Filed September 19, 1995
D.C. Me.]

[Caption omitted in printing]

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BY MS. PERLEY:
Q. Dr. Bragdon, you testified last week that you had reviewed your own expert report, that of Dr. Kuvin, that of John Molinari and that of Dr. Greenspan. Had you reviewed anything else in preparation for the deposition?
A. No.
Q. Had you looked at the deposition transcript from the case known as Doe versus Bragdon?
A. Yes.
Q. Had you ever read the opinion from United States versus Morvan?
A. Yes.
Q. And when was that?
A. About four weeks ago, I think.
Q. Did you review any of the other expert reports from the Morvan case besides that of Dr. Greenspan?
A. I – during one of our breaks, John McCarthy gave

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A. He thought there was a risk in the office and that he didn't have the training and knowledge to treat an HIV positive patient.
Q. Did you agree with his position?
A. Yes.
Q. Do you think you have the training and knowledge to treat a person with HIV?
A. Not completely, but basically, yes.

Q. When you say not completely, what do you mean by that?
A. Well, our knowledge of HIV and treatment is increasing exponentially, and it's a continually changing sort of thing, so it takes quite a bit of effort to keep up.
Q. But for the most part, you think you do have the knowledge to treat a person with HIV?
A. Yes.
Q. Okay. Have you reviewed anything since last week's deposition in preparation for today?
A. As far as case notes and whatnot, no.
Q. Did you look at any particular articles since last Wednesday?
A. I looked at the ADA Journal that came in yesterday, and there's been a couple MMWRs.
MR. McCARTHY: You are swallowing you

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words just a little bit.
A. Okay. I will try to talk more clearly for you.
Q. What MMWRs are you referring to?
A. The one that came last week and the one that came in the mail yesterday.
Q. Did either one contain any pertinent articles about HIV or tuberculosis or anything related to this case?
A. The one last week contained an article about transmission from patient to patient in Columbia, a dialysis patient.
Q. When you say patient to patient, transmission of what?
A. HIV.
Q. And what did the article said?
A. The article said that the transmission appeared to have occurred as a result of a dialysis patient seroconverting after dialysis had been begun for that patient and that the cause was believed to be sharing the same needles for the entry into the patient's body, and then disinfecting them in a quatramonium disinfectant, which isn't approved in

this country.
Q. Is or is not?
A. Is not.

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Q. And why isn't it approved?
A. Because it's been found ineffective against HIV.
Q. Were these needles heat sterilized or only cold sterilized?
A. They were cold sterilized.
Q. Okay. And what was your reaction to the article?
A. I don't know as there was any reaction.
Q. Okay. Did you review any other documents in preparation for today?
A. No.
Q. Nothing else at all?
A. No.
Q. Did you review the transcript from last week's deposition?
A. No.
Q. What about the articles that your counsel provided to us at the end of last week, did you provide those to your counsel after the deposition?
A. Yes, I did.
Q. And what did you do to find those particular articles?
A. Just went back to my office and pulled them out.
Q. And your reason for pulling out those particular articles was what?
A. You had asked for them.

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Q. Okay. Besides Dr. Kuvin, Dr. Day, -- I'm sorry, you said you did not talk to Dr. Kuvin. Besides Dr. Day and Dr. Morvan, have you discussed the facts of this case with any other so-called expert?
MR. GILBERT: Are you talking about potential trial experts or are you talking about people who are so-called retained experts, or are you talking about people just in the field

generally?

MS. PERLEY: All of the above.

A. As far as other retained experts, no. I suppose I have talked about the case to a number of colleagues and whatnot as far as casual conversation goes, and a number of patients too.

BY MS. PERLEY:

Q. When you say a number of colleagues, are you talking within the Bangor area or outside of Bangor?

A. Both.

Q. Have you talked to anyone outside of the State of Maine?

A. Yes.

Q. At your initiation or at theirs?

A. Both.

Q. Where have these conversations occurred?

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A. Yeah, 60. That would be a ratio of somewhere between one in 50, one in 60.

Q. What, in your view, is the risk of transmission in your dental office of HIV from an infected patient to a member of your staff?

A. If they receive a percutaneous injury, it would be the same.

Q. And again, can you quantify the risk of a staff member receiving a percutaneous injury from a particular patient?

A. No, I don't think I can.

Q. What, in your view, is the risk of transmission in your dental office of HIV from an infected patient to another patient in your office?

A. What is the risk?

Q. Of transmission of HIV from an infected patient to another patient in your office.

A. I don't know.

Q. Is it your position that there have been documented instances of transmission of HIV in the dental office from an infected patient to a dental health

care worker?

A. Repeat that question, please.

MS. PERLEY: Could you please repeat it.

(Pending question read back.)

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A. What do you mean by documented?

Q. What do you mean by documented?

A. You are asking the question.

Q. I'm asking – you can answer it however you want, your understanding of what is a documented instance of transmission.

A. The CDC has different classifications for reporting, and technically they don't list any documented transmissions, but I believe now they list seven dental workers for which they can find no other risk factor, and then in the OSHA blood pathogens standard OSHA reported that CDC had reported to them that there was documented transmission.

Q. In a dental office?

A. Yes. That doesn't seem to appear in the documentation, so I'm not sure if they were using two different sets of criteria or what.

Q. To your knowledge, other than the seven instances which you just described are there any other instances of transmission that you know about from an infected patient to a dental health care worker in the dental office?

A. No.

Q. Are there any instances that you know about,

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documented or undocumented, of transmission from a dental health care worker to a patient?

A. Did you say other instances?

Q. Any instances that you know of of transmission of HIV from a dental health care worker to a patient in the dental operatory.

A. The Dr. Acer/Kimberly Bergalis case.

Q. Anything other than that?
A. No.
Q. To your knowledge, are there any instances of transmission, documented or undocumented, from an infected patient to a noninfected patient in the dental operatory?
A. There's I believe it's the Sharp's case that was in Massachusetts which is felt that there may have been a transmission from patient to patient by nonheat sterilized hand pieces or some other mode.
Q. Anything else?
A. That's the only one I know of of patient to patient.
Q. So am I correct then that to your knowledge there have been seven undocumented possible instances of transmission from patient to health care worker, only one possible case of transmission from health care worker to patient and only one possible case

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of transmission from patient to patient in the dental operatory, is that correct?
A. That's correct.
Q. Okay. With the Sharp's case you said you believe it's because of the unsterilized hand piece, is that right?
A. That was what they cited as being what they felt was the primary problem.
Q. Do you know whatever happened to that case?
A. No, I don't.
Q. So you don't know if it's ever been proven the there was actual patient to patient transmission?
A. No.
Q. Given your infectious disease policy I take it that you believe the risk of transmission of HIV in the dental operatory in your office is not acceptable to you, is that right?
A. That's right.
Q. But you're willing to treat the patient – an HIV positive patient in the hospital operatory, is that right?

A. Yes.
Q. So that risk is acceptable to you, right?
A. It's the best I can do.
Q. Last week when we were talking you mentioned a ....

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Q. And if the patient indicates that they do not have TB, do you treatment in the office?
A. Yes.
Q. But you don't do that for people who are HIV positive, is that right?
A. Don't do what?
Q. Let me withdraw the last question. Do you do any screening at all to determine whether some patient may have a higher than average risk of being – of having tuberculosis?
A. We don't do any group screening at all.
Q. Have you contacted any dentist about being an expert witness for you in this case?
A. No.
Q. Have you contacted any dentist and asked for their opinion about your infectious disease policy?
A. No.
Q. Dr. Bragdon, in the documents that you have produced to us in this case there were copies of the magazine Pause. Are you familiar with that magazine?
A. Yes.
Q. And can you tell us how you came into possession of the magazine Pause?
A. There were issues of it given out at the meeting in

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Chicago.
Q. And that's the meeting in October of 1994?
A. Yes, it was.
Q. Can you tell me all of the journals that you subscribe to currently?

A. I may not remember them all.
Q. At the current time.
A. I get the Journal of the American Dental Association – do you want publications, too, or just journals?
Q. Everything that you get in the mail that's a journal or a publication.
A. Okay. The ADA News, the Journal of the Academy of Dentistry, AGD Impact Magazine. I get the newsletter of the International Dental health Foundation, the publication of the American Orthodontic Society, the publication of the International Association of Orthodontics, the Journal of the International Physicians for AIDS Care. They have changed the name. I can't remember exactly. I think that's pretty close. Dental Economics, Dentistry Today. These are – aren't really journals, they are just kind of publications. That's pretty much it.
Q. What are the journals or publications that you

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subscribe to or receive currently other than the dental journals that you have just referred to?
A. Pardon?
Q. What are the journals or publications that you currently subscribe to or receive other than dental journals you have just named?

MR. GILBERT: Are you asking him what he puts out in his waiting room, Reader's Digest or that type of thing?

MR. KLEIN: I'm asking everything that he receives in the office or at home.

MR. GILBERT: Well, that would include what he puts out in the waiting room, Reader's Digest. Is that what you want?

A. Reader's Digest, Good Housekeeping, Popular Mechanics, Country Home, Reminiscing.
Q. Pardon?
A. Reminiscing.
Q. Are those journals that you subscribe to for

purposes of putting out in your waiting room?
A. Yeah.
Q. What other journals do you personally subscribe to and receive at home or the office other than things that you are intending to put out on your waiting room table?

(Page 593)

A. That's pretty much it.
Q. You don't receive any journals or publications that are not related to dentistry?

MR. McCARTHY: You mean other than Good Housekeeping?

MR. KLEIN: Pardon?

MR. McCARTHY: I guess I'm misunderstanding.

Q. Are there any journals other than Reader's Digest, Good Housekeeping, Popular Mechanics, Country Home and Reminiscing that you subscribe to that are not dental journals that you have not already named?
A. That's all I can remember right now.
Q. Do you receive any publications from the Maine Dental Association?
A. Oh, yes, MDA Journal.
Q. Are there any other publications of the Maine Dental Association you receive?
A. That's a newsletter that comes out once a month.
Q. Are there any other Maine Dental Association publications or journals which you receive?
A. That's the only thing they put out on a regular basis. Then there's a monthly newsletter from the Penobscot Valley Dental Society.
Q. Are there any other publications of the Penobscot ....

DEPOSITION EXHIBIT 13 TO BRAGDON DEPOSITION OF JUNE 13-14, 1995

[Filed September 19, 1995
D.C. Me.]

PATIENT REGISTRATION AND HEALTH RECORD

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

[PATIENT RESPONSES ITALICIZED]

Date: *09/16/94*

Marital status: *Divorced*

Name: *Sidney Abbott*

Phone: *989-7017*

Address: *16 State St., Apt. E, Brewer, Maine, 04412*

Referred by: *a friend*

Employed by: *Penobscot Area Housing*

Position: *Dir. Serv. Worker*

Business address: *215 French St., Bangor, Maine*

Phone: *942-3994*

In case of emergency, who should be notified: *Melinda Perrier*

Phone: *947-2367*

Person responsible for this account: *Me*

Social Security No.: *006-68-6050*

Medical Health

General health: *Good*

Are you presently under the care of a physician: *Yes*

What medications are you presently taking: (blank)

Physician: *Rob Pinskey*

Last complete physical: *Jan.*

What disorders are you presently being treated or have been treated for within the past year: *HIV*

Please list any serious illness within the past five years, not listed above: (blank)

Have you been told by a physician that you should have prophylactic antibiotics before having dental procedures done: *No*

General Health

Tire easily: *No*

Headaches: *Yes*

Night sweats: *No*

Persistent fever: *No*

Glaucoma: *No*

Persistent cough: *No*

Sputum (phlegm) production: *No*

Cough up bloody sputum: *No*

Marked weight change: *No*

Shortness of breath: *No*

Have you been diagnosed or treated for:

Heart disease; Asthma or hay fever; Rheumatic or Scarlet fever; Abnormal blood pressure; Congenital heart lesions; Tuberculosis or lung disease; Diabetes; Epilepsy; Anemia; Ulcers; Jaundice; Hepatitis; Sinus trouble; Cough; Arthritis; Stroke; Glaucoma; Immune deficiency disease; Autoimmune disease; AIDS: *No* [to all the above.]

Heart murmur; HIV positive: *Yes*

Have you ever had radiation therapy: *No*

Chemotherapy: *No*

Are you allergic to penicillin; Codeine; Local injected anesthetics; other allergies: [blank]

Other medications: *Bactrim.*

Are you subject to prolonged or unusual bleeding, fainting spells or dizziness: *No*

Are you pregnant: *No*

Dental Health

Reason for visit: *Tooth ache*

Have you ever had any serious trouble associated with previous dental treatment: *No*

Does dental treatment make you nervous: *Slightly*

Does dental treatment make you nervous: *Slightly*

Date of last dental visit: *August, 1994*

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth): *No*

Do you have or have you ever had any of the following:

Mouth

Bleeding, sore gums; biting cheeks/lips; sensitive to sweets: *Yes*

Unpleasant taste/bad breath; burning tongue/lips; frequent blisters, lips/mouth; swelling/lumps in mouth; ortho treatments (braces); clicking; popping jaw; difficulty opening or closing jaw; loose teeth; sensitive to hot, cold; sensitive to biting; food impaction; clenching/grinding; shifting of teeth; change in bite: *No*

Do you use the following:

Brush, dental floss: *Yes*

Fluoride rinse: *No*

How often do you brush: *Twice a day*

Brush is soft, medium, hard: *Medium*

Toothpaste: *Tom's.*

Are you familiar with the term "preventive dentistry:" *Yes*

/s/ Sidney Abbott

Date: 09/16/94

DEPOSITION OF DONALD CRAVEN, M.D., TAKEN IN BOSTON, MASSACHUSETTS ON JULY 21, 1995

(Caption omitted in printing)

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(Page 70)

Q. Am I correct that there are patients who are HIV positive and have no symptoms?

A. Yes.

***

Q. Are some of your patients pregnant?

A. Yes.

(Page 71)

Q. And do you treat any patients who are pregnant? I guess I'm using "you" broadly. Do you treat these patients yourself?

A. Some.

Q. Do you treat some of these patients who are HIV positive and are pregnant with AZT?

A. Yes.

Q. Does that have a positive effect?

A. Yes.

Q. Does that in some cases permit them to bear children successfully?

A. It doesn't have to do with bearing children. It has to do with decreasing the transmission of the virus to their child.

Q. Thank you. So in some of these cases where you're treating

pregnant women, you among other things treat them with AZT, and that reduces the likelihood that the child will be born after having had the HIV virus transmitted to it?

A. Yes.

Q. To what extent is that successful?

A. The latest studies that have been published suggest that women treated throughout pregnancy, at birth and after pregnancy and

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children that are born and treated for a period of time after birth decreases transmission 67 percent. 25 percent in an untreated AZT group or 8 percent for AZT treated women. There's a two-thirds reduction of infectivity of the children.

Q. So the infectivity rate to begin with is 25%?

A. Right.

Q. And with the treatment of AZT it can be reduced to 8 percent?

A. In one study.

Q. Is that a reliable study?

A. Yes.

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(Page 118)

Q. Do you sometimes recommend to HIV positive patients that they not get pregnant?

A. I don't make recommendations about pregnancy to patients. I discuss what the risks are and what the concerns are and leave the decision about pregnancy to the patient, unless there's an overall compelling reason why the woman's health would be

greatly impaired if she became pregnant having to do with issues aside from HIV.

Q. And in order to make that judgment, you would need to obtain a history from the patient, and you'd need to look at her medical records; is that right?

A. In general I don't make recommendation to women. Let me make it more categorical than that. I have not made a recommendation to a woman yet. But I could see if there were some circumstances, that I would make a recommendation to any woman if I felt that pregnancy would impair her health that she should consider not becoming pregnant.

(Page 119)

But I leave the decision about pregnancy to the woman. I try to provide information about what the risks are and what the different values are, but the decision to become pregnant is not one that I take a stand on with a patient. I basically try to inform them and let them make the decision based on the information about risk that I give them.

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AFFIDAVIT OF DONALD E. CRAVEN, M.D. DATED 09/13/95

[Caption omitted in printing]

I, Donald M. Craven, M.D., state as follows:

1. I am a professor of Medicine and Microbiology at Boston University School of Medicine and Professor of Epidemiology and Biostatistics at Boston University School of Public Health. I have been the Director of the Clinical AIDS Program at Boston City Hospital since 1990. I have been the primary care physician for more than 75 patients with human immunodeficiency virus (HIV) or acquired immunodeficiency virus (AIDS) and have been a consultant for hundreds of patients with HIV or AIDS. I incorporate into this Affidavit my Curriculum Vitae (Exhibit A) and the opinions set forth in my Expert Report in this case (Exhibit B).

2. HIV is a retrovirus which is the causative agent of AIDS. A person who has been infected with HIV will, after a period of one to six months, develop antibodies, thus becoming HIV-positive. The collection of illnesses which characterizes AIDS may not appear for seven to twelve years after seroconversion. During much of this period, an HIV-positive person may be asymptomatic.

3. However, even when asymptomatic, an HIV-positive person is infectious and has abnormalities in the blood and immune systems. When HIV enters the body, it begins to multiply and has an immediate and destructive effect on the hematologic (blood) and lymphatic systems. HIV destroys the T-4 lymphocyte and other white blood cells, which are critical to the body's defense against infection. In addition, HIV destroys the body's lymph glands which are the command center for the immune system's attempt to contain infection. Thus, even before the onset of overt symptoms, HIV infection causes a progressive destruction of the body's blood, lymphatic and immune systems.

4. The modes of transmission of HIV are well

known. HIV is transmitted by sexual contact with an infected person; exposure to blood or blood products; or from an infected mother to her child during pregnancy, child birth or breast feeding.

6.[sic]. In order to estimate the number of dental procedures performed in the United States since 1982, I am making the following assumptions. I assume that there are 150,000 practicing dentists. See Distribution of Dentists in the United States by Region and State, American Dental Association, 1991, Exhibit C. In addition, I am told that Dr. Bragdon testified that he sees about sixty patients per week. I will make a conservative estimate that Dr. Bragdon actually performs dental procedures on thirty patients per week. I am therefore assuming that most general dentists perform dental procedures on about 30 patients per week. I assume that the average dentist works 48 weeks per year.

8.[sic]. Based on those assumptions, I calculate that there have been 2.8 billion dental procedures performed in the United States from 1982 to present. If I assume that the average dentist performs only 15 procedures per week, the number of dental procedures since 1982 would be 1.4 billion. These estimates do not include the 100,000 dental hygienists in the United States (See Exhibit D). If dental hygienists were included, the number of dental procedures performed since 1982 would be significantly higher.

9. Since 1982, the United States Centers for Disease Control and Prevention (CDC) has monitored occupational transmission of HIV in the health care setting. During that time, there has not been a single documented case of HIV transmission from a patient to any dental health care worker, including dentists, hygienists and chairside assistants. Based on the current epidemiological data, the probability of HIV transmission in the future from patient to dental health care worker is infinitesimally small or negligible, and significantly less than the risk of death in many other events both within and outside the health care setting which are commonly treated as reasonably safe activities.

10. Since 1982, there have not been any documented cases of patient-to-patient transmission of HIV in the dental setting.

11. There is a wide spectrum of risk associated with a variety of health care procedures. For example, risk of dying from acute anaphylaxis from penicillin is between 1 in 50,000 and 1 in 100,000, resulting in approximately 400 to 800 deaths per year. See Erffmeyer, Adverse Reactions to Penicillin, Annals of Allergy, Vol. 47, October 1981, p. 288, Exhibit E; Landesman, The HIV-Positive Health Professional, Archives of Internal Medicine, Vol. 151, April 1991, p. 655, Exhibit F. The risk of death from anesthesia is 1 in 400,000. See Voelker, Anesthesia-Related Risks Have Plummeted, Journal of the American Medical Association, February, 1995, Vol. 273, No. 6, Exhibit G.

12. According to the most recent National Safety Council statistics, which are for the year 1986, there are also risks associated with everyday activity. The risk of death from a motor vehicle accident in Bangor, Maine is 9.5 per 100,000 population per year. In 1986, 119 people died from falling into a hole or other opening in a surface. In that same year, 78 people died as a result of being struck by lightning. See excerpts from Accident Facts, published by the National Safety Council, Exhibit H.

SIGNED UNDER THE PENALTIES OF PERJURY THIS 13th day of September 1995.

/s/ Donald E. Craven, M.D.

[EXHIBIT A]

CURRICULUM VITAE

Donald Edward Craven

PERSONAL INFORMATION:

Birth: January 13, 1944, Omaha, Nebraska

Address: Home:
20 Clifford Street
Wellesley, MA 02181
617-237-7851

Office:
Boston City Hospital
818 Harrison Avenue
Boston, MA 02118
(617) 534-4800 FAX 534-7818

Family: Kathleen Walsh Steger
Natalie Adrienne (9/84)
Hillary Elyse (4/88)
David Allen (4/82)
Jenny Lee (4/84)

SS# 094-34-4205

EDUCATION & PROFESSIONAL TRAINING:

1966 BA, Wesleyan University, Middletown, Conn.
1970 MD, Albany Medical College, Union University, Albany, NY
1970-71 Intern, Albany Medical Center Hospital, Albany, NY
1971-74 Resident and Fellow in Medicine, Royal Victoria Hospital, McGill University, Montreal, Canada
1974-76 Fellow in Infectious Diseases, Boston University, Boston, MA
1976-79 Research Associate, Bureau of Biologics, National Institutes of Health, Bethesda, Md.

ACADEMIC APPOINTMENTS:

1989- Professor of Medicine and Microbiology, Boston University School of Medicine (BUSM), Boston, MA
1989- Professor of Epidemiology and Biostatistics, Boston University School of Public Health (BUSPH)
1984-88 Associate Professor of Epidemiology and Biostatistics, BUSPH
1986-88 Associate Professor of Microbiology, BUSM

1983-88 Associate Professor of Medicine, BUSM
1982-83 Assistant Professor of Epidemiology and Biostatistics, BUSPH
1979-83 Assistant Professor of Medicine, BUSM

MEDICAL APPOINTMENTS:

1989- Director of Clinical AIDS Section, Boston City Hospital
1988- Associate Visiting Physician, Boston City Hospital
1990-93 Associate Director of Medicine, Boston City Hospital
1987-88 Associate Director of the AIDS Clinic, Boston City Hospital
1987-88 AIDS Public Health Director, Department of Health & Hospitals
1980-87 Director of Hospital Epidemiology, Boston City Hospital
1979-88 Assistant Visiting Physician, Boston City Hospital
1979-87 Hospital Epidemiologist, Boston City Hospital
1984-88 Lecturer, Harvard Medical School
1984-90 Staff Associate, University Hospital
1986-88 Lecturer Boston University Dental School
1986-89 Lecturer, Harvard School of Public Health
1974-76 Emergency Room Physician, Memorial Hospital, Nashua, NH
1973-74 Associate Director, ID Clinic, Royal Victoria Hospital
1976-79 Mountain Medicine, Editor & Writer, Potomac Appalachian Club
1971-73 Emergency Room Physician, Memorial Hospital, Watertown, NY
1971-73 Clinic Director, John Abbott College, Montreral, Canada

AWARDS:

1995 Who's Who: Most Outstanding Americans
1991-94 Best Doctors in America
1988-94 Teaching Award, BU School of Public Health
1989-94 Who's Who on the Frontiers of Science
1986 Governor's Recognition Award for AIDS Research
1970 Alice E. Fruehan Award for Outpatient Medicine

1970 Lamb Foundation Prize for Medicine
1969 Cancer Society Fellow, Christie Hospital, Manchester, England

CERTIFICATION:
1971 National Board of Medical Examiners
1973 American Board of Internal Medicine, Internal Medicine
1973 Medical Council of Canada (LMCC)
1975 Royal College of Physicians, Internal Medicine
1982 American Board of Internal Medicine, Infectious Diseases

MILITARY SERVICE:
1970-73 Captain, United States Air Force Reserve
1976-79 Senior Surgeon, US Public Health Service, National Institutes of Health, Bethesda, Md.

MEMBERSHIPS & FELLOWSHIPS:
1981-95 Fellow American College of Physicians
1983-95 Fellow Infectious Diseases Society of America
1976-93 Fellow Royal College of Physicians and Surgeons of Canada
1974-95 American Society of Microbiology
1979-95 Society of Health Care Epidemiology of America
1979-95 Massachusetts Public Health Association
1988-95 American Public Health Association
1979-95 American Association for the Advancement of Science
1980-95 American Federation of Clinical Research
1987-95 American Thoracic Society
1989-93 Critical Care Society

NATIONAL, STATE AND CITY COMMITTEES:
1991-95 Hospital Infection Control Practices Advisory Committee
(HICPAC) Centers for Disease Control, Atlanta, GA
1992-94 HICPAC-Chairperson for CDC Guideline for Prevention
of Nosocomial Pneumonia
1993-94 President, Society of Hospital Care Epidemiology of America (SHEA)

1991-93 Vice-President (President-elect), SHEA
1994-95 American Thoracic Society, Bacterial Infections Assembly
1992 International Program Committee-VIII International Conference on AIDS/STD World Congress, Amsterdam,
the Netherlands
1992 Ad-Hoc Study Section on AIDS, National Heart and Lung
Institute, National Institutes of Health, Bethesda, Md.
1992 Chairman, Search Committee for Editor, Hospital Epidemiology and Infection Control
1989-91 Advisory Board for International Infection Control Conference, Freiburg, Germany
1986-91 AIDS Action Committee Advisory Board
1988 Site Visit Team for National Institute for Childhood Diseases Program Project on AIDS, San Francisco General Hospital
1986 National Institute of Childhood Diseases, Study Section on AIDS
1986-88 Study Group on AIDS and Public Policy, Harvard University
1986-89 Mayor's Committee on AIDS
1990-91 Governor's Task Force on AIDS
1987-91 Massachusetts Hospital Association—AIDS Advisory
Committee
1988-89 Women and Intravenous Drug User Task Force: AIDS Consortium
1984 Reviewer for Heritage Fund, Calgary, Alberta, Canada
1985 National Institutes of Allergy and Infectious Diseases, National Institutes of Health, Special Study Section

HOSPITAL COMMITTEES:
1994 Microbiology Chairperson, Search Committee
1989-92 Clinical Research Center Advisory Board, BUSM & BCH
1988-92 AIDS Task Force, Boston City Hospital
1987-93 Pharmacy and Therapeutics Committee
1979-92 Infection Control, Boston City Hospital
1980-88 Critical Care Units, Boston City Hospital

1980-87 PSRO Committee, Boston City Hospital
1981-87 Institutional Review Board for Human Studies, Boston
City Hospital
1987 Internship Selection Committee, Boston City Hospital

EDITORIAL CONSULTANT:
New England Journal of Medicine
Journal of Infectious Diseases
Reviews in Infectious Diseases
Archives of Internal Medicine
Journal of American Medical Association
American Journal of Medicine
Hospital Epidemiology and Infection Control (Editorial Board)
Chest
American Review of Respiratory Disease
Journal of the American Medical Association (JAMA)
European Journal of Infectious Diseases and Microbiology
Critical Care Medicine
Acquired Immunodeficiency Syndrome

CONSULTANT:
1995 Anneburg Group, Continuing Education for Primary Care Providers
1992-95 Data Safety Monitoring Board, Use of Monoclonal Antibody Against Tumor Necrosis Factor (TNF) for the treatment of Septic Shock, Myles Laboratories
1994-95 Consultant, SmithKlein-Beecham
1994 Consultant, Infectious Diseases in Primary Care, Abbott
1982-87 Hepatitis, Merck, Sharp and Dohme
1982-85 Consultant, Mattapan & Long Island Hospitals, Boston, MA
1984 Reviewer for Heritage Fund, Calgary, Alberta, Canada
1985-88 Health Conference on Aging, New York, New York
1985 National Institute of Allergy and Infectious Diseases National Institutes of Health, Special Study Section
1985-88 Medical Advisory Board, Laboratory of Cellular Immunology and Cancer Diagnosis, Boston University School of Medicine

GRANTS:
Over 100 grants from NIH, NIDA, CDC, Massachusetts Department of Public Health, City of Boston, and Pharmaceutical Companies.

[Scientific Papers and Research omitted from appendix]

[EXHIBIT B]
EXPERT REPORT OF DONALD E. CRAVEN, M.D.
(Undated)

[Caption omitted in printing]

Pursuant to Federal Rule of Civil Procedure 26 (a) (2) (c), this report sets forth the opinions I will advance to rebut the reports of Sanford Kuvin, M.D. and Randon Bragdon, D.M.D. I have reviewed the expert reports of Dr. Bragdon and Dr. Kuvin and the first volume of Dr. Bragdon's deposition conducted on June 5 and June 6, 1995.

I am a Professor of Medicine and Microbiology at Boston University School of Medicine and Professor of Epidemiology and Biostatistics at Boston University School of Public Health.

I have been the primary care provider for more than 75 patients with human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS) over the past eight years and have been an AIDS/Infectious Disease Consultant for hundreds of inpatients and outpatients with HIV disease or AIDS. I am familiar with the diagnosis, treatment and mode of transmission of HIV and the various secondary manifestations of AIDS.

I have been the Director of the Adult Clinical AIDS Program at Boston City Hospital since 1990. I have also been the AIDS Public Health Director, the Director of Hospital Epidemiology, and a member of the Infection Control Committee at Boston City Hospital. In these positions, I have been responsible for the implementation, monitoring and surveillance of the hospital's procedures for the control and prevention of infectious diseases, including those in the hospital's dental clinic.

During 1993-1994 I was the President, and during 1991-1993 I was the Vice-President and President-elect, of the Society of Hospital Care Epidemiology of America (SHEA). From 1991-1995, I served on the Hospital Infection Control Practices Advisory Committee (HICPAC) of the United States

Centers for Disease Control (CDC). I have also been elected as a Fellow of the Infectious Diseases Society of America, the American College of Physicians and the Royal College of Physicians and Surgeons of Canada. My additional credentials to provide this expert opinion are contained in my Curriculum Vitae.

Based upon my education, experience and expertise, I expect to advance the following opinions in this case:

1. HIV is a retrovirus which is the causative agent of AIDS. HIV is transmitted by sexual intercourse, exposure to infected blood or blood products, or vertically from an infected mother to an infant.

2. Medical history does not necessarily reveal a patient's HIV status. The majority of patients with HIV are asymptomatic and do not develop medical complications which result in a diagnosis of AIDS for more than ten years. Based on my understanding of the epidemiology and pathogenesis of HIV disease, many people with HIV may not be aware that they are infected.

3. The United States Occupational Safety and Health Administration ("OSHA") and public health authorities such as the CDC have established standard infection control procedures to prevent the transmission of HIV and other bloodborne pathogens from patients to health care workers, from health care workers to patients, and from a patient- to-patient in the health care setting. The fundamental principle of these standard infection control procedures is that all patients must be treated as potentially infectious for all bloodborne pathogens, including HIV, or hepatitis B virus (HBV).

4. The standard infection control precautions ("Universal precautions") established by CDC and OSHA include: barrier techniques such as wearing protective gloves, masks, and gowns; handwashing and changing gloves after each patient; sterilization of instruments; cleaning and disinfection of environmental surfaces in the patient treatment area; and proper disposal of contaminated needles or sharp instruments.

5. No infection control procedures above and beyond the use of the standard infection control procedures established by CDC and OSHA are necessary for the provision of general dentistry services to persons with HIV infection or AIDS. So long as standard infection control procedures are utilized, it is just as safe to treat a dental patient in a private dental office as in a hospital setting.

6. Although HBV and HIV are both blood borne pathogens, they are significantly different with respect to their infectiousness. The viral titre of HBV – i.e., the number of virions per unit of blood – is significantly greater than HIV. In addition, HBV is a much stronger, heartier virus which can survive an inanimate surfaces[sic] for longer periods of time and under more adverse conditions than HIV.

7. To the extent that Dr. Bragdon will only treat HIV-positive patients in a hospital setting because of concerns that HIV-positive patients will transit[sic] Mycobacterium tuberculosis (MTB) to others in the private dental setting, that concern is not justified by current principles of epidemiology and infection control for tuberculosis (TB).

8. MTB is a bacteria which causes TB. MTB is transmitted by inhalation into the lungs of infectious respiratory droplets or sputum from the trachea or lung of a person with active TB. Most people infected with TB do not have active disease. Rather, the disease is latent and noninfectious.

9. The vast majority of people who have active TB are not infected with HIV. A patient's HIV status does not indicate whether or not the patient has latent or active TB. In addition, while HIV-infected persons are at increased risk to proceed from latent infection to active TB, many other persons who are not HIV-infected are also at greater than average risk to proceed from intent to active TB. These higher risk groups include the elderly and and [sic] immunocompromised patients, such as patients with leukemia, diabetes, Hodgkins disease, or persons receiving cancer chemotherapy or other immunosuppressive medications.

10. Active TB is diagnosable and treatable. Any patient with symptoms of TB, regardless of his or her known HIV status, should be sent for TB evaluation prior to receiving dental treatment. If the patient is diagnosed as having active pulmonary TB, the patient should not receive elective dental treatment. The patient should be provided with standard antituberculosis drug treatment. As a result of receiving appropriate treatment, the patient will be noninfectious in approximately two weeks. At that time, the patient may receive dental treatment.

11. Cytomegalovirus (CMV) is a virus which is primarily transmitted through sexual intercourse or exposure to infected blood. CMV is not casually transmitted.

12. Staphylococcus aureus and streptococci are bacteria which are prevalent in all populations, regardless of HIV status.

13. Herpes simplex virus (HSV) types 1 and 2 cause cold sores in the mouth or on the lips. HSV is common in the entire population. HSV infection may be latent (that is, may exist without the manifestation of a sore). HSV is transmitted through contact with infected saliva or kissing. The standard infection control procedures prevent transmission of HSV to health care workers.

14. The various opportunistic infections which people with AIDS may experience do not present a threat to the health of other patients in private health care settings.

15. There is no evidence that HIV is spread through aerosolization.

16. I am not aware of any evidence that HIV survives in water.

17. Dr. Bragdon's infectious disease policy has no scientific or epidemiological basis. Because there is no sound method of determining which patients have infectious diseases, standard infection control procedures, such as those established

by CDC and OSHA, must be used or practiced universally for all patients.

In addition to the publications and documents listed in my Curriculum Vitae, the documents which I reviewed to formulate my opinions include but are not limited to those listed in the attachment to this report.

S/Donald E. Craven, M.D.

DOCUMENTS REVIEWED BY
DONALD E. CRAVEN, M.D.

1. Centers for Disease Control and Prevention: Recommended Infection Control Practices for Dentistry. Morbidity and Mortality Weekly Report (MMWR) 1986; 35:237-241.

2. Centers for Disease Control and Prevention. Recommendations for Prevention of HIV in Health-Care Settings. MMWR 1987; 36 (No. 25).

3. Centers for Disease Control and Prevention: Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B, and Other Bloodborne Pathogens in Health-Care Settings, MMWR 1988: 37:377-382.

4. Centers for Disease Control and Prevention: Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers. MMWR 1989:38 (Suppl. No. S-6): 1-37.

5. Centers for Disease Control and Prevention: Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus during Exposure-Prone Invasive Procedures. MMWR 1991: 40(No. RR-8).

6. Centers for Disease Control and Prevention Recommended Infection Control Practices for Dentistry (1993).

7. Snyder DE, Raviglione M, Kochi A. "Global Burden of Tuberculosis", In: Tuberculosis: Pathogenesis Protection and Control, Barry R. Bloom, editor, ASM Press, Washington D.C. 1994, pp 3-12.

8. Hopewell PC. "Overview of Clinical Tuberculosis" In: Tuberculosis: Pathogenesis Protection and Control, Barry R. Bloom, editor, ASM Press, Washington D.C. 1994, pp. 25-46.

9. Smith PG and Moss AR. "Epidemiology of Tuberculosis" In: Tuberculosis: Pathogenesis Protection and Control, Barry P. Bloom, editor, ASM Press, Washington D.C. 1994, pp 47-61.

10. CDC: "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", 1994, MMWR, October 28, 1994, Vol. 43, #RR13, pp 1-132.

11. CDC: "Guidelines for Preventing Transmission of Tuberculosis in Health Care Settings with Special Focus on HIV-Related Issues", MMWR, 1990, vol. 39, #RR-17, pp. 1-40.

12. American Thoracic Society/CDC: "Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children", 1994 Am J Respir Crit Care Med 1994; 149; 1359-1374

13. Robinson WS. Hepatitis B Virus. In: Principles and Practice of Infectious Diseases, editors: Mandell GL, Bennett JE and Dolin R, Churchill Livingston, New York, 1995, pp. 1406-1439.

14. United States Occupational Safety and Health Administration: Occupational Exposure to Bloodborne Pathogens, 29 CFR Part 1910, 1991.

15. Hirsch MS. Herpes Simplex Virus. In: Principles and Practice of Infectious Diseases, editors: GL Mandell, JE Bennett, R Dolin, Churchill Livingston, New York, Fourth Edition, 1995, pp. 1136-1344.

16. MO M. Cytomegalovirus In: Principles and Practice of Infectious Diseases, editors: GL Mandell, JE Bennett, R Dolin, Churchill Livingston, New York, Fourth Edition, 1995, pp. 1351, 1363.

17. Waldvogel FA. Staphylococcus Auerus. In: Principles and Practice of Infectious Diseases, editors: GL Mandell, JE Bennett, R Dolin, Churchill Livingston, New York, Fourth Edition, 1995, pp. 1754-1776

18. Bisno AL. Streptococcus Pyogenes. In: Principles and Practice of Infectious Diseases, editors: GL Mandell, JE Bennett, R Dolin, Churchill Livingston, New York, Fourth Edition, 1995, pp. 1786-1796.

DEPOSITION OF DAVID KENNEDY, M.D. DATED 09/01/95

[Caption omitted in printing]

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(Page 5)

Q. All right. And what is the – is that done on an hourly - is there a minimum time-based unit or charge such as 15 minutes or an hour or so forth?

A. There are two types of charges. One is what we call a full operating room charge, and that's generally for inpatients; and then for outpatients we use something called OR/Minor, which there is no minimal charge. The unit of measure is one minute. It's so many dollars per minute. So it could be very little.

Q. Okay. And what would that come to – what would the OR charge be for one hour of time?

A. For OR/Minor?

Q. Yes.

A. I believe it's $5 a minute today. So 60 times 5 is, what, $300? Is that right?

Q. Now, what is the hourly charge for a full operating room?

A. That I don't know off the top of my head.

Q. Is it fair to say it is a greater charge than for OR/Minor?

A. Much greater.

Q. Okay. Would you say – is it your understanding that it would be at least double?

A. Probably triple.

(Page 6)

Q. Does the hourly rate for OR/Minor include – strike that. Let me rephrase the question. Are the OR/Minor rooms ever used by physicians who have privileges at the hospital but are not on the permanent regular staff of the hospital?

A. Rarely but they are used, yes.

Q. Okay. And are the OR/Minor rooms ever used when a physician or other health care provider brings his own equipment and supplies to the hospital?

A. As far as equipment and supplies, I really wouldn't know.

Q. Okay. So you're not aware of whether a physician or other health care provider has ever brought their own supplies and equipment for use in one of the other OR/Minor rooms, is that right?

A. I am not aware of that, no.

Q. Would the charge to a physician include all of the time that the physician or health care provider is actually using the OR/Minor space including any time that they would need to use the space to set up their own equipment?

A. I don't quite understand the question. You said a charge to a physician. I don't think we charge a physician for using the facility.

Q. Okay. I misspoke. Let me clarify that. The

(page 7)

patient is the person who is charged for the use of OR/Minor, is that right?

A. Correct.

Q. And is the patient charged for the entire time that the room is being occupied or used by the physician or health care

provider in connection with the services for the patient?

A. For OR/Minor, I believe that today we are charging from what they call a cut to close, meaning from the time that the patient is actually operated on until the physician is finished and may even leave the room. For inpatient care the charge, I believe, is for threshold to threshold, the time the patient crosses into the room until the time the patient leaves the room.

Q. If a physician needed to use OR/Minor for a period of time to set up equipment and supplies, let's assume just for purposes of this example half an hour of time or an hour of time, would that be included in the patient charge?

A. For OR/Minor I don't believe it would, and usually with OR/Minor there is very little of that setup, and the physician generally doesn't do that. It's my understanding that the nursing

(Page 8)

staff usually has that ready before the patient gets there.

Q. Okay. So is it correct to say that for billing purposes the hospital has never encountered a situation in which an outside provider needed significant time to set up their own equipment and supplies?

A. No to my knowledge.

Q. Okay. And would somebody at the hospital have to make a determination about how that time would be billed?

A. Yes. There is a certain amount of discretion that is used by the head nurse in the operating room, and that's really the person who does the charging. The billing department doesn't actually do the charging. I oversee a lot of the functions and the framework for charging, but the actual charging is done by the OR head nurse.

Q. I just need one moment to see if I have any further

questions. (Brief pause) Directing your attention to Exhibit 1, the second page says OR/Minor, and the patient balance is $1,015. Do you see that?

A. Yes.

Q. And then below it indicates that the time was ...

A Short Critique of the
Recommended M.D.A. AIDS Access Policy
Randon Bragdon, D.M.D.

I hope that you find this critique of the Recommended M.D.A. AIDS Access Policy useful in coming to you own more fully informed conclusions.

> "1. It is unethical for us to refuse to treat a patientt (sic) who is HIV-positive, based solely upon this diagnosis."

Who is "us" anyway. It certainly does not include many dentists and dental schools. It is <u>not</u> unethical to refuse to treat based upon the fact that the patient is infectious with a transmittable disease. On page nine of the April 8, 1991 issue of the A.D.A. News an article titled "Barrier Techniques on Trial in HBV Case" describes how the State University of New York at Buffalo Dental School has a policy of not knowingly treating infectious HBV patients or allowing infectious HBV students in the clinic. I encourage you to read this article (copy enclosed). It makes it clear that to knowingly expose a dental school clinic or private dental office to infectious diseases places that school or office legally liable for any transmitted infectious diseases regardless of what precautions are observed. It <u>is not unethical</u> to treat all infectious diseases the same. What <u>is unethical</u> is to treat one infectious disease differently from others! HIV is a deadly infectious disease and must be treated as such. It is not a passport to special privileges!

> "2. Dental Care for HIV-positive patients can be performed in the private practice setting using universal precautions and medical consultations as necessary."

This statement is patently false! The studies necessary to prove this have <u>never</u> been made. How meaningful are "medical consultations" when the necessary studies have never been made? In fact all evidence to date points to the exact opposite. The oral surgeons have never been able to protect themselves from HBV by "universal precautions." Even the C.D.C. estimates that there are about three times as many dentists HIV+ than surgeons! (Yes, I know that HBV is <u>supposed</u> to be more infectious than HIV. But let me ask you

this; "Are tens of thousands in this country and millions worldwide dying of HBV or AIDS?)

> "3. Information regarding the patient's disease status should be confidential. If it is deemed necessary to advise other health care providers, the patient's consent should be obtained."

This statement is at once unethical and also in direct opposition to statement number two. How would a dentist have "medical consultations" if he was not allowed to discuss a patient's HIV+/AIDS status? Is it ethical for a general dentist to refer a HIV+/AIDS patient to, for example, an oral surgeon or a periodontist without advising of the HIV+/AIDS status? Would the reverse be ethical?

> "We strongly believe that all patients, including those HIV-positive, have the right to go to the dentist of their choice for treatment. In addition, we feel that an equitable policy needs to incorporate some means for sharing responsibility for treating HIV-positive patients among all practicing dentists in the state. To this end, our committee proposes the following method for insuring access to care for HIV-Positive Patients:"

Again who are "we"! I do not believe that there is a single dentist in the country who has not refused treatment to at least several patients for good reasons. Nobody has completely free choice of either health care facility or provider. An expectant woman in the Bangor area has a choice of only one hospital if she wants an area obstetrician. Furthermore, if she delivers or needs a c-section on the weekend she gets whoever is doing rotation that weekend. She has no choice! When my wife and I moved to Bangor she was seven months pregnant with our daughter. No obstetrician in the area would take her on as a patient! We ended up with a G.P. who had been rehabilitated from drug abuse. (I am not complaining. He did a good professional job. I am just pointing out that my wife had no choice!) Why should persons infected with not only HIV but also a multitude of other infectious diseases have special privileges that even pregnant women are not entitled to?

The law for the practice of dentistry has always been one of mutual consent. The patient freely agrees to be treated and the practitioner freely agrees to treat.

It is not a question of availability of dental care for HIV+/AIDS persons. There are dentists and specialists who are willing to treat them. HIV+/AIDS persons comprise less than 0.3% of the population of the state. Clearly, only a small percentage of the dentists in the state are needed to treat them. Why should 100% of the Maine dental offices be exposed to the danger of an epidemic deadly infectious disease to accommodate 0.3% of the population. The 99.7% HIV free deserve and need protection from infectious disease too.

> "1. Patients of record remain with their dentist."

No one is recommending the abandonment of patients. However, the medical or emotional or infectious status of a patient may change. As a result, a dentist may not feel that he/she can safely of (sic) adequately treat that patient. This may require the dentist to refer the patient elsewhere. For example, I personally feel that HIV+/AIDS patients should be treated in a hospital environment. I do not feel that a private dental operatory can compare to a hospital operatory.

> "2. Patients of record referred to a specialty practice retain the referring dentist as their primary care provider."

This takes away the right of a dentist to decline to continue to be a primary care provider when he/she does not feel that it can be safely done. The rest of the dentist's patients have rights, too.

> "3. Patients without a dentist of record are encouraged to have their caseworker or physician contact the Maine Dental Association to obtain a dental care provider.

There is nothing wrong with the M.D.A. helping find practitioners who want to freely accept certain patients. However, my being taken to task for not <u>wanting to treat a mentally ill AIDS patient</u> proves that you cannot imagine a situation severe enough that they would not want to force you to

treat against your best judgment.

> "We suggest that the Maine Dental Association provide at least two choices from a list of dentists, by town, published by the Maine State Board of Dental Examiners.
>
> "1. If possible, dentists will be chosen from the patient's home town in alphabetical order, rotating down the listing, or, when indicated:
>
> "2. From a list of adjacent community dentists chosen on a similar fashion."

This completely takes away the right of a dentist to chose (sic) who he/she is willing to treat. It takes away your right to take what measures you deem prudent to protect your patients, staff, and family from infectious diseases. The M.D.A. or A.D.A. will not rush in and make everything better if you have major problems as a result of following their "AIDS Access Policy." If you do not believe me, just write either the M.D.A. or the A.D.A. and ask them for a written statement that they will accept all responsibility for any malpractice suits that <u>might arise from following their Recommended Policies to the letter</u>. For example, suppose a mentally ill AIDS patient bites a staff member or patient. Do you really think the M.D.A. will rush in and make everything better? I have my doubts.

> "The M.D.A. Central office will record all referrals and complaints regarding access. Dentists will be responsible for reporting the date of the initial appointment and the outcome (kept or failed) to the M.D.A. Central Office. Complaints will be directed to the appropriate committee for investigation and resolution. Unresolved complaints will be forwarded to the Maine State Board of Dental Examiners."

This paragraph in effect makes the M.D.A. Executive Council presenting itself as the "Ethics Committee" an <u>administrative court for enforcing the "Recommended M.D.A. AIDS Access Policy"</u>! If you have any doubt about this read the enclosed correspondence of the M.D.A. Executive Council calling itself the "Ethics Committee" persecuting me for "not wanting the (sic) treat a <u>mentally ill Aids patient</u>" and my policy

of not treating infectious diseases. In reading this correspondence you will see that the "Ethics Committee" can operate rather unprofessionally. There is a salient point that must be understood in the action that the "Ethics Committee" took against me. <u>There was no complaint from BMHI</u>. BMHI has known and respected my policy of not treating infectious patients for twelve years! BMHI did call and ask my receptionist if I "<u>would want to treat mentally ill AIDS patients</u>." (There are probably not ten other dentists in the state who could make a stronger case that they do not discriminate against the handicapped.) I have treated hundreds of mentally handicapped patients. I have never had any complaint from BMHI in quality of care. Nor has BMHI had any objections to my infectious disease policy. Superintendent H. Lawrence Ventura reconfirmed on March 21, 1991, that <u>BMHI had respected my infectious disease policy for twelve years and has no problem with continuing that policy</u>. Please consider the impossibility of treating to the complete satisfaction of those you are serving and having a <u>third party able</u> to made (sic) a complaint! We do not need an administrative court in the M.D.A!

I feel strongly that the Recommended M.D.A. Access Policy is ill conceived and would be detrimental to the dental profession.

RECOMMENDED MDA AIDS ACCESS POLICY

The MDA concurs with the American Dental Association regarding the treatment of HIV-infected patients:

1. It is unethical for us to refuse to treat a patient who is HIV-positive, based solely upon this diagnosis.
2. Dental Care for HIV-positive patients can be performed in the private practice setting using universal precautions and medical consultations as necessary.
3. Information regarding the patient's disease status should be kept confidential. If it is deemed necessary to advise other health care providers, the patient's consent should be

obtained.

We strongly believe that all patients, including those HIV-positive, have the right to go to the dentist of their choice for treatment. In addition, we feel that an equitable policy needs to incorporate some means for sharing responsibility for treating HIV-positive patients among all practicing dentists in the state. To this end, our committee proposes the following method for insuring access to care for HIV-Positive Patients:

1. Patients of record remain with their dentist.
2. Patients of record referred to a specialty practice retain the referring dentist as their primary care provider.
3. Patients without a dentist of record* are encouraged to have their caseworker or physician contact the Maine Dental Association to obtain a dental care provider.

We suggest that the Maine Dental Association provide at least two choices from a list of dentists, by town, published by the Maine State Board of Dental Examiners.

1. If possible, dentists will be chosen from the patient's home town in alphabetical order, rotating down the listing, or, when indicated:
2. From a list of adjacent community dentists chosen on a similar fashion.

The MDA Central office will record all referrals and complaints regarding access. Dentists will be responsible for reporting the date of the initial appointment and the outcome (kept or failed) to the MDA Central Office. Complaints will be directed to the appropriate committee for investigation and resolution. Unresolved complaints will be forwarded to the Maine State Board of Dental Examiners.

*Dentist of record is defined as one who provided a continuity of care over the last calendar year, including complete examination, charting, and treatment planning, not just emergency care.

Ed. Note: This policy will be presented to the membership on June 21st at the MDA Annual Meeting.

Removing the Rhetoric and Exposing the Grim Reality, Aids and Dentistry

Randon Bragdon, D.M.D.

The purpose of the following comments is to remove the rhetoric that has been concealing the grim reality of AIDS which is on a collision course with the dental profession.

We often hear the rhetoric that it is embarrassing that HIV+/AIDS individuals cannot get into any dental office they wish. There are serious consequences to being infectious with a deadly disease for which there is no known cure nor is one expected. What is truly embarrassing is that there is not more being done to protect the 99+% part of the public. Also, it is truly embarrassing that it was a twenty-two year old girl who first proved that HIV could be transmitted from dentist to patient. Why was it not first proven in either the dental or medical profession? That is embarrassing. It is embarrassing that national infection control standards are being made and enforced by OSHA. It is a sad commentary that the A.M.A./A.D.A. has not been in such a bastion of infection control that OSHA could not infringe on that turf. After all, OSHA also sets the standards for handling concrete. Yes, there are a lot of embarrassing things. But the fact that there are unpleasant consequences to contracting a deadly disease is not embarrassing—it is tragic and unfortunate.

"HIV infection can be controlled by education and safe sex."

We have concluded a ten year test of these two fallacies. In 1981, the first case of AIDS was diagnosed. That year there were only a handful of cases. Over 650 of the early cases were traced to so called "patient zero," a homosexual airline steward. The first proven case of AIDS was a homosexual sailor who died of AIDS in England in 1959. This case was reported in Lancet, October 29, 1960, as a puzzling case. It was proven to be AIDS from saved tissue last year. AIDS has a long latency. It was stated at the 1991 Yankee Dental Congress that the majority of the AIDS cases of the 90's were contracted in the 70's. "In a follow up study of a segment of 6,875 San Francisco

homosexual men seen at a clinic between 1978 and 1980, the number testing positive for AIDS infection increased from a modest 4.5 percent in 1978 to an epidemic level of 74.5 percent in 1985." (H.W. Jaffe et al., Ann of Int Med 1985; 103:210-214.) The homosexual subculture has saturated itself with HIV infection. The new HIV infections in homosexuals mostly reflect recruitment. Even the incidence of syphilis and gonorrhea in homosexuals is about twice as great as it was ten years ago! So much for education! There is no such thing as "safe sex". It does not prevent pregnancy much less infectious disease. One of the most vocal nationally known instructors in "safe sex" was diagnosed as having AIDS recently. Apparently taking his own advise did not work very well.

If we go through the 90's with the same cavalier attitude that we went through the 80's with, our society will be hopelessly diseased.

The N.Y. medical delivery system is fast being overwhelmed by AIDS. In some N.Y. hospitals nurses are being paid over $70K per year, up from $22.5K about four years ago. Even at over $70K per year, most American nurses will not work in N.Y. hospitals. Many of the nurses are from Mexico and the Philippines.

The "experts" that are telling us that there is no transmission of HIV in dentistry do not have a good track record. They are the same ones who said that only 10% of the HIV+ would die of AIDS. In 1982, they said you could not get HIV from blood! The CDC authored the "swine flu epidemic and vaccine" debacle. A vaccine that paralyzed over 1,000 for a epidemic that never existed! At the January '91 Yankee Dental Congress, we were told by one "expert" that a "drop of HIV+ blood on your clothing, hair, or skin" from a patient would be noninfectious "the moment it dried". From this ludicrous statement you might conclude that blow dryers should be a part of "universal precautions"!

Over 75% of AIDS patients have dementia. In fact this is often the only manifestation of the disease. AS a result they cannot be expected to act and think completely normally.

It is a myth that dental workers have nothing to fear if they observe "universal precautions". We make wide use of sharp instruments and needles. Who has not looked at his/her gloves and seen holes "that were not there before!" I think there has been a lot of confusing of good luck with good judgment.

I would like to quote James Tusky, M.D. chief resident at a California hospital, who said he spent years denying the risk of HIV infection to doctors. Then in his third year he stuck himself with a needle he had just withdrawn from a male AIDS patient.

> "My world changed. The feeling you get looking down and seeing blood oozing out of your finger is one that I hope no one here will ever have. It changed my life. It changed my sex life."
>
> James Tusky, M.D.

A recent survey of internal medicine residents and internists at the three teaching hospitals in San Francisco revealed that 55% had been stuck by needles known to be withdrawn from AIDS patients. Where is the compassion for the innocently infected healthcare workers?

It is a proven fact that coughed aerosols containing TB and HIV remain viable for up to a week. It requires a leap of faith to believe that a aerosol particle containing enough TB bacteria to infect would not contain enough HIV virons to infect.

In vitro HIV infection by handpiece aerosols is now a proven fact.

The fact that HIV+/AIDS persons carry a number of other diseases cannot be ignored. What if a HIV+/AIDS patient in your office transmits CMV to another pregnant patient or staff member? The baby may either be horribly deformed or die! Who will be sued? Suppose that a HIV+/AIDS patient has a "conservative treatment"—e.g. a prophy and scaling. It would not be surprising that the patient's gingiva would bleed freely. After the dental treatment the patient goes into the bathroom and spits all over the sink and/or toilet because he/she does not

like the taste of blood. He/She then wipes his/her mouth with his/her hand. Then touches the flush handle, the bathroom doorknob and the front door doorknob of your office. Then a child or adult with a open lesion on their hand touches the front door doorknob, the bathroom doorknob, and the flush handle. This is to say nothing about the possible condition of the sink and toilet!

TB is increasing greatly. Transmission requires only a common ventilation system. The patient that contracts TB does not even have to be in the same room the same day! With DNA sequencing the malpractice lawyer will be able to prove that their client's TB bacillus came from a HIV+/AIDS patient that was in your office. HE/She will be further able to prove that your office was the only closed ventilation system the client and the HIV+/AIDS TB carrier had in common.

There is a big difference in liability between knowingly exposing patients to infectious disease and unknowingly exposing patients. This makes the argument we should knowingly treat HIV+/AIDS patients because we may have unknowingly treated completely fallacious.

Remember when the AIDS patients first began to pour into San Francisco and Los Angelos (sic) hospitals? Nurses were forbidden to wear gloves because AIDS homosexuals were offended that nurses "did not want to touch their bare skin with their bare hands." To forbid the donning of gloves was unreasonable then and absurd in retrospect. These are the same activists who are trying to tell us how to control infection in our offices today.

Some experts told dentists in the past that washing gloves was an acceptable practice. It is now well accepted that gloves should be changed and not washed. Were those of us who have always changed gloves at fault in the past?

The experts used to tell us to cut needles. Now we are told not to "because it splatters blood." The splatter caused by cutting needles is nothing compared to the splatter that occurs during many dental procedures.

The transmission of infectious disease is more complex than the present state of our understanding. One surgeon with HBV was permitted to practice with patient's informed consent by double gloves and other extraordinary precautions. Within six months he had a proven HBV transmission to a women (sic) for whom he had done a c-section. The mode of transmission is still not understood.

What are the consequences of overreacting to the threat of infectious disease versus under-reacting? Overreacting is, I believe, the safer course. Because the homosexual subculture has generally accepted the rhetoric instead of the reality of the HIV/AIDS danger, they are almost all infected. If the homosexual subculture had adopted a lifesaving fear of contracting HIV/AIDS, this country would not be confronted with the reality of the present AIDs epidemic.

We may not be able to set everything right in this world, but we should be free to set our own offices as right as possible.

Declaration of Deborah Greenspan, BDS, DSc, ScD (hc), FDS RCSEd (Hon)

Executed on September 17, 1995

(Caption Omitted in Printing)

Pursuant to 28 U.S.C. § 1746, I Deborah Greenspan, BDS, DSc, ScD (hc), FDS RCSEd (hon) declare that:

I hold a Bachelor of Dental Surgery and a Doctor of Science in oral medicine from the University of London, England, an honorary Doctor of Science from Georgetown University, Washington, D.C., and an honorary Fellowship in Dental Surgery from the Royal College of Surgeons at Edinburgh. I am currently Clinical Professor or Oral Medicine at the University of California at San Francisco and am also Chair of the committee on Infection Control and Compliance at the UCSF School of Dentistry. At the dental school, I have treated over one thousand patients who are HIV-positive. In addition, I have supervised many dental students and residents, who routinely treat HIV-positive patients in the dental clinic and use the same infection control procedures as can and should be used in a private dental office.

I have written and lectured extensively on HIV and the practice of dentistry. My education, professional experience, and publications are more fully set forth on my Curriculum Vitae, attached hereto.

I have read the following documents generated in this case:

A. Expert Report of Randon Bragdon, DMD

B. Infectious Disease Policy of Randon Bragdon, DMD

C. Expert Report of Sanford Kuvin, MS, MD, DTM & H

D. Expert Report of Deborah Greenspan, BDS, DSc

E. Expert Report of John Molinari, PhD

F. Expert Report of Donald Craven, MD

G. Deposition of Randon Bragdon, DMD

In addition, I have read the deposition of Randon Bragdon, D.M.D., as well as the exhibits attached thereto, in the case known as John Doe v. Bragdon, C.A. No. CV-93-63 (Me. Sup. Ct.).

Based on my education, experience and expertise I offer the following opinions in this case:

1. HIV is a retrovirus and is the causative agent of the Acquired Immune Deficiency Syndrome ("AIDS").

2. Persons exposed to HIV may contract the virus, and, after a period of one to at most six months, will develop HIV antibodies, thus becoming HIV-seropositive. The collection of symptoms that characterizes AIDS may not appear for seven to ten years after seroconversion. During much of this period, persons who are HIV-positive may be asymptomatic but are infectious.

3. As HIV infection progressive to AIDS, immunodeficiency develops. AIDS is characterized by severe opportunistic infections or malignancies arising with progressive compromise of the immune system.

4. Persons with HIV and persons with AIDS have a continuing need for routine dental services such as those provided by general dentists like Dr. Bragdon.

5. HIV is transmitted through (1) sexual contact with exchange of body fluids with an infected person, (2) invasive exposure to infected blood or blood components, and (3) perinatally from mother to neonate. HIV is not an airborne pathogen and there is no evidence to suggest that it can be transmitted by aerosols in the dental office. Sexual contact with exchange of body fluids constitutes the major risk factor for transmitting or contracting HIV infection. Intravenous drug use with shared needles is also a major risk factor.

6. In the 14 years since AIDS was first recognized, there has been not one documented case of transmission of HIV in the dental health care setting from infected patient to dental health care worker. Similarly, there has been not one documented case of transmission of HIV from infected patient to another patient in the dental setting. This epidemiological evidence clearly demonstrates that it is safe to treat persons with HIV/AIDS in the private dental office setting.

7. In 1986 the Centers for Disease Control and Prevention ("CDC") issued Recommended Infection-Control Practices for Dentistry. In 1987 the CED issued Recommendations for the Prevention of HIV Transmission in Health-Care Settings, including dentistry. In 1991 the Occupational Safety and Health Administration ("OSHA") issued its final rule on Occupational Exposure to Bloodborne Pathogens, which protects, among other persons, all dental employees. In 1993 the CDC issued revised Recommended Infection-Control Practices for Dentistry.

8. All of the above guidance recommends the use of "universal precautions" – infection control procedures wherein each patient is treated as if infectious for HIV, Hepatitis B, and other bloodborne pathogens. Universal precautions must be utilized in the dental setting because dental health care workers have no way of knowing whether or not the patient that they are treating is infectious. So long as universal precautions are used, HIV-positive patients may be safely treated in the private dental office.

9. In the dental setting, universal precautions include the use of protective attire, such as gloves, gowns, protective eyewear, surgical masks, and/or face shields; proper sterilization of all dental instruments, including the autoclaving of dental handpieces after each use; and proper disinfection of the dental unit and operatory surfaces.

10. No additional infection control procedures – above and beyond universal precautions – are required to provide dental treatment to persons with HIV infection or AIDS. There is no need for any of the additional procedures outlined in Dr. Bragdon's expert report, other than those already recommended

by the CDC and OSHA.

11. There is no medical or scientific basis whatsoever for Dr. Bragdon's infectious disease policy. The entire premise underlying universal precautions is that all patients should be treated as potentially infectious for HIV, Hepatitis B, Hepatitis C, and other bloodborne pathogens.

12. Indeed, the entire purpose of universal precautions is to obviate any need for an infectious disease policy such as Dr. Bragdon's. The use of such a policy is neither appropriate nor necessary in any dental setting, including a private dental office.

13. With respect to the issue of infection control, there is no difference in treating a dental patient in a dental school clinic, a hospital setting, or a private dental office. Universal precautions should be universally employed when treating a dental patient, regardless of the treatment environment. So long as such precautions are properly utilized, it is just as safe to treat a patient in a private dental office as it is to treat a patient in a hospital setting.

14. To the extent that there have been cases of occupationally acquired HIV in the health care setting, the transmissions have resulted not from the failure of universal precautions, but rather, from accidental injuries (e.g., accidentally being stuck with a contaminated needle). There is no evidence that providing dental treatment to a person with HIV in a hospital operatory in any way reduces the risk of accidental injuries. In fact, the majority of accidental injuries resulting in occupationally acquired HIV have occurred in the hospital setting.

15. No special training or expertise, other than that possessed by a general dentist, is required to provide general dental care – including basic restorative dentistry, such as the filling of a cavity – to persons with HIV infection or AIDS. No such specialty is recognized by the dental profession.

16. While it is true that some persons with HIV might require specialized care for a particular oral condition – for example, hairy leukoplakia or a severe periodontal condition –

the patient should be referred by their general dentist to a specialist only for the particular treatment required. When such a referral is made, the patient is expected to return to the general dentist for the provision of subsequent routine dental care.

17. In 1988, the American Dental Association's House of Delegates adopted its current policy on the treatment of persons with HIV or AIDS. The policy states, among other things:

> The Association believes that HIV-infected individuals should be treated with compassion and dignity. Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.
>
> A sound approach to the treatment of infectious patients requires an assessment of the patient's condition based on reasonable and informed medical judgments, given the state of medical knowledge at the time. A dentist should not refuse to treat a patient whose condition is within the dentist's current realm of competence solely because the patient is HIV-infected.

American Dental Association, 132nd Annual Session 539 (1991).

18. Dr. Bragdon's position that he will only treat persons with HIV/AIDS in a hospital setting is in direct contravention of the American Dental Association's policies, and, as a dentist, I therefore believe that they constitute a breach of his professional obligations.

19. There is no medical or scientific justification for Dr. Bragdon's refusal to treat Sidney Abbott in his dental office. Dr. Bragdon's refusal to treat Sidney Abbott is in direct contravention of the American Dental Association's policies.

20. To the extent that Dr. Bragdon's refusal to treat HIV-positive persons in his office is based on his concern that such persons might be infectious for tuberculosis (TB), Dr. Bragdon's position has no merit. Most people with infectious TB are not HIV-positive. Although it is true that HIV-positive persons are at a higher risk for progression from latent TB infection to active disease than the general population, this is true for many other populations as well (e.g., children less than four years of age, the elderly, individuals with chronic renal failure with renal dialysis, individuals with diabetes mellitus, and individuals who are immunocompromised, such as those undergoing chemotherapy).

21. If a dental patient is known or believed to be infectious for TB, dental treatment should be postponed until the person has been evaluated, and, if infectious for TB, until the person no longer is infectious. (If emergency treatment is required – e.g., if the patient has a life threatening dental condition – then the patient would need to be seen in an appropriate specialized setting.) Postponing dental treatment or treating in a specialized setting because the patient has TB, regardless of the person's HIV status, is a separate and distinct issue from refusing to provide dental care in a private dental office solely because a person has HIV/AIDS. There is no medical or scientific basis for denying dental care on the basis of a person's HIV status alone.

22. While it is true that HIV and Hepatitis B (HBV) are both bloodborne pathogens, HBV is a significantly more infectious and more easily transmitted virus than HIV.

23. As health care workers, we must base our policies, practices, and procedures on current scientific knowledge.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

/s/ Dr. Deborah Greenspan
University of California at San Francisco
School of Dentistry
513 Parnasus Ave., Box 0442, S-612
San Francisco, CA 94143

University of California, San Francisco

CURRICULUM VITAE
Prepared May 2, 1995

NAME: Deborah Greenspan

CURRENT TITLE AND DEPARTMENT:

Clinical Professor of Oral Medicine
Department of Stomatology
School of Dentistry

MAILING ADDRESS:

Box 0422, S-612
University of California, San Francisco
San Francisco, California 94143
Phone: (415) 476-3080
Fax: (415) 476-4204

EDUCATION:

Dates Attended: 1958-60

Institution and Location:

Royal Free Hospital
School of Medicine
University of London, England

Degrees Conferred, Title or Status: 2nd BDS

Major Subject: Basic Sciences

Dates Attended: 1960-64

Institution and Location:

Royal Dental Hospital of London,

School of Dental Surgery, University
of London, England

Degrees Conferred, Title or Status: BDS

Major subject: Dentistry

Dates Attended: 1964

Institution and Location:

Royal College of Surgeons,
England

Degrees Conferred, Title or Status: LDS RCS

Major subject: Dentistry

Dates Attended: 1976-78

Institution and Location:

University of California, San Francisco,
Department of Oral Medicine and Hospital
Dentistry

Degrees Conferred, Title or Status: Fellow

Major subject: Oral Medicine

Dates Attended: 1991

Institution and Location:

University of London, England

Degrees Conferred, Title or Status: DSc (Med)

Major subject: Oral Medicine

LICENSES, CERTIFICATIONS, ETC.:

1964	Royal College of Surgeons of England, Licentiate in Dental Surgery
1964	Registered Dental Practitioner, United Kingdom
1977	National Board of Dental Examiners, Parts I and II
1978	Certificate in Oral Medicine

BOARD CERTIFICATION:

1985	Diplomate, American Board of Oral Medicine

PRINCIPAL POSITIONS HELD:

1964-65	Dental Group Practice, Wembley, England - Associate
1965-76	Private Practice and National Health Service - Dentist (Owner and director of two general dental practices employing three dentists and five staff personnel)
1972	University of California, San Francisco - Lecturer in Oral Biology
1976-83	University of California, San Francisco - Visiting Lecturer in Oral Medicine
1983-85	University of California, San Francisco - Assistant Clinical Professor of Oral Medicine
1985-1989	University of California, San Francisco - Associate Clinical Professor of Oral Medicine
1989-now	University of California, San Francisco - Clinical Professor of Oral Medicine

ANCILLARY POSITIONS HELD:

1987-now	Clinical Director, UCSF Oral AIDS Center

HONORS AND AWARDS:

1978-79	Fellow of National Cancer Institute, Department of Oral Medicine and Hospital Dentistry, University of California, San Francisco
1984-now	Faculty Member, Rho Rho Chapter, Omicron Kappa Upsilon, Dental Honor Society

1986	Award for Teaching Excellence in Oral Medicine from Class of 1987
1986	Woman of Distinction Award, London, UK
1988	Fellow, American College of Dentists
1988	Annenberg Lecture. Alpha Omega Dental Society. London, England.
1989	Samuel Charles Miller Award, American Academy of Oral Medicine
1989	Seymour J. Kreshover Lecture, National Institute of Dental Research
1989	Assistant Secretary for Health, Certificate of Commendation
1990	ScD(hc). Honorary Degree, Doctor of Science, Georgetown University, Washington DC
1991-now	Honorary Lecturer, United Medical and Dental Schools of Guys and St. Thomas Hospitals, University of London, England
1991	Honorary Visiting Professor, Faculty of Dentistry, University of Queensland, Brisbane, Australia
1992	Nevin Lecture. University of Colorado, Denver, Colorado
1992	Commencement Speaker, Eastman Dental Center, Rochester, New York
1993-now	Who's Who in America
1993	Fellow, Pierre Fauchard Academy
1993	Fellow of the American Association for the Advancement of Science
1994	Distinguished Visiting Professor, Beth Israel Medical Center, New York
1994	FDS RCSEd, Honorary Fellowship in Dental Surgery, Royal College of Surgeons
1994-now	Dictionary of International Biography

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS:

1964-76	Royal Society of Medicine, London (Associate)
1960-79	British Dental Association
1979-now	International Association for Dental Research
1979-now	American Association for Dental Research
1979-now	American Academy of Oral Pathology
1983-now	American Society of Microbiology
1983	American Society for Cancer Chemotherapy

1985-now	American Association of Women Dentists
1986-now	American Association for the Advancement of Science
1986-now	American Academy of Oral Medicine
1986-now	American Association of Dental Schools
1986-now	International Association of Oral Pathologists
1986-now	American Dental Association
1986-now	California Dental Association
1986-now	San Francisco Dental Society
1987-now	Royal Society of Medicine, London (Fellow)
1988-now	International AIDS Society
1992-now	American Public Health Association

SERVICE TO PROFESSIONAL ORGANIZATIONS:

1986-87	IADR/AADR, Experimental Pathology Group, Member at Large, Executive Committee
1986-89	AADR, Session Chairman
1987	IADR/AADR, Moderator, symposium on Smokeless Tobacco, Chicago, Illinois
1987	American Medical Association, AIDS and Public Policy. Chicago, Illinois
1987	Testifying before a Joint Sub-committee of California Legislature on Health Effects of Tobacco representing California Dental Association, Sacramento, California
1988	IADR/AADR, Organizer and Moderator, Symposium on Papillomaviruses, Montreal, Canada
1988-89	IADR/AADR, Experimental Pathology Group. Program Chair
1988-91	AADR, Constitution Committee, Member. Chair 1990-91
1988-now	American Dental Association. Visiting Lecturer, Speaker's Bureau
1988	Testifying before the House Appropriations Committee, Sub-Committee on Labor, Health and Human Services and Education, representing the American Association of Dental Research, Washington, D.C.
1988-now	American Dental Association, Consultant, Council on Dental Therapeutics

1989-90	Vlth International Conference on AIDS 1990. Planning Committee Track 11, Clinical Sciences
1989	National AIDS Update 1989. Advisory Committee
1989	AIDS and Dental Education. Symposium participant. American Association of Dental Schools, San Francisco, California
1988-89	IADR/AADR, Experimental Pathology Group, President-Elect
1989-90	IADR/AADR, Experimental Pathology Group, President, Executive Committee
1989	Committee on Curriculum Guidelines for Infectious Diseases American Association of Dental Schools, Centers for Disease Control, HRSA, Washington, DC
1990	Testifying before the Human Resources Task Force, Committee on the Budget, House of Representatives; representing the American Association of Dental Schools, San Francisco, California
1990	Occupational Hazards in Dentistry: Risk, Perception and Response. Participant, Joint AADR/AADS Symposium, Cincinnati, Ohio
1990	Opportunities in Science, Careers in Dental Science. Participant, IADR/AADR Symposium, Cincinnati, Ohio
1990-1	AADR, San Francisco Section, President
1991-1994	AADR, Treasurer
1991	IADR/AADR Oral Infections In The Immunocompromised Host. Co-Chair, Symposium, Acapulco, Mexico
1991	IADR/AADR, Dental Implications of AIDS. Science Transfer Seminar, Acapulco, Mexico
1991	Australia and New Zealand Division IADR. Impact of the AIDS Epidemic on the Dental Profession. Symposium participant, Brisbane, Australia
1991	Australia and New Zealand Division IADR. Session Chair, Brisbane, Australia
1992	AADR. Oral Opportunistic Infections in HIV disease. Science Transfer Seminar. Boston, Massachusetts

1992 Opportunities in Science Careers in Dental Science. Participant in AADR Outreach Symposium. Boston, Massachusetts

1992 International Congress on Oral Medicine, Session Chair. Edinburgh, Scotland

1992 Ad hoc reviewer: Grants and Allocation Committee, American Fund for Dental Health

1993 Testifying before the House Appropriations Committee, Sub-Committee on Labor, Health and Human Services and Education, representing the American Association of Dental Schools, Washington, DC

1993 Opportunities in Science Careers in Dental Science. Participant in AADR Outreach Symposium. Chicago, Illinois

1993 Oral Candidiasis: Clinical implications, pathogenesis and therapy. Co-Chair IADR/AADR Symposium, Chicago, Illinois

1993 Testifying before the Institute of Medicine, Committee on the Future of Dental Education, Washington, DC

1994-5 Immediate Past Treasurer, American Association for Dental Research

1994-5 Member, Organizing Committee International Conference on Oral Biology, IADR

1995 Distinguished Speaker. Student Research Group Meeting. American Association for Dental Research, San Antonio, Texas

1995 AIDS Dental Reimbursement. Symposium Moderator. American Association of Dental Schools, San Antonio, Texas

SERVICE TO PROFESSIONAL PUBLICATIONS:

1983-88 Journal of Oral Pathology - Ad Hoc Referee

1985-now Cancer - Ad Hoc Referee

1986-now Journal of the Academy of General Dentistry - Ad Hoc Referee

1986 European Journal of Cancer & Clinical Oncology - Ad Hoc Referee

1988-now Archives of Dermatology - Ad Hoc Referee

1988-now Journal of the American Medical Association - Ad Hoc Referee

1991-now AIDS - Ad Hoc Referee

1991-now Journal of Acquired Immunodeficiency Syndrome - Ad Hoc Referee

1991-1994 Journal of The American College of Dentists - Editorial Board of Review

1991-now Journal of Dental Research - Ad Hoc Referee

1991-now Journal of the American Dental Association - Ad Hoc Referee

1992 Community Dentistry and Oral Epidemiology - Ad Hoc Referee

1992-now Journal of the California Dental Association - Ad Hoc Referee

1992 Journal of Oral Pathology and Medicine - Ad Hoc Referee

1993-now Journal of Oral Pathology and Medicine - Editorial Board of Review

1993-4 Special Care in Dentistry - Ad Hoc Referee

1994 New England Journal of Medicine - Ad Hoc Referee

SERVICE TO GOVERNMENT:

1987 Consultant for Review of Guidelines for Prevention of Transmission of HIV Infection in Health Care Workers (two meetings). Centers for Disease Control, Atlanta, Georgia

1987,88 Consultant; NIDR AIDS Task Force. NIDR, Washington, DC

1987 Consultant; Task Force on AIDS and Dental Education. AADS, CDC and HRSA. Washington, DC

1987-now Ad Hoc reviewer for ROI applications. Epidemiology and Disease Control Study Section, Division of Research Grants, NIH

1988 Consultant; Multidisciplinary Curriculum Development Conference on HIV Infection. Workshop Leader: Provider Responsibility: Legal and Ethical Issues. Bureau of Maternal and Child Health and Resources Development. HRSA. Baltimore, Maryland

1988 Member of Objective review Committee, AIDS

Regional Education and Training Centers. Bureau of Maternal and Child Health and Resources Development. HRSA. Rockville, Maryland

1989 Speaker: NIH Consensus Development Conference. Oral complications of cancer therapies: Diagnosis, prevention and treatment

1989 Member: Ad hoc committee on smoking cessation in the dental office. National Cancer Institute, Rockville, Maryland

1989-now Member: Programs Advisory Committee of the National Institute of Dental Research

1989 Participant: HIV/AIDS Surveillance and Epidemiology Briefing. WHO/GPA. Berkeley, California

1990 Consultant: NIDR HIV Oral Health Research Activity at The Walter Reed Army Medical Center, Washington, DC

1990 Member: Special ad hoc Review Committee for Program Project application. NIDR

1991-1993 Member: National Panel for The Development of Clinical Practice Guidelines for HIV and AIDS. Agency for Health Care Policy and Research

1991-1994 Member: Dental Products Panel, Center for Devices and Radiological Health, Food and Drug Administration

1991 Member: Special ad hoc Technical Review Panel. NIDR

1992 Ad hoc reviewer: Small Grants Review Committee. NIDR

1992 Ad hoc reviewer: Small Grants Application Agency for Health Care Policy and Research

1993 Ad hoc reviewer: Small Grants Review Committee. NIDR

1994 Member: Workshop for strategic planning. Office of AIDS Research. Washington, DC

1994 Consultant: Dental Products Panel, Center for Devices and Radiological Health, Food and Drug Administration

CONSULTANT:

1986 Consultant to the Working Party on AIDS,

European Economic Community Bureau of Health, Copenhagen, Denmark

1987 AIDS Services Evaluation Project. Northwestern University Dental School, Chicago, Illinois

1988 AHEC. Train-the-Trainer program, UCSF

1989 Oral AIDS Project, Louisiana State University Medical Center1989-94

1989-94 Joint FDI/WHO working group on AIDS

1989 Reviewer: Medical Research Council, United Kingdom

1990 Consultant: European Economic Community Clearinghouse on Oral Problems Related to HIV Infection and World Health Organization Collaborating Center on Oral Manifestations of HIV infection, Amsterdam, Holland

1991 Consultant: Panel on Guidelines for the Infected Health Care Worker; Dept. of Health, State of California, representing the California Dental Association

1991 Consultant: Prevention of HIV and Hepatitis B in The Health Care Setting World Health Organization, Geneva, Switzerland

1991 Consultant: AIDS Task Force, San Francisco Medical Society

1992 Consultant: European Economic Community Clearinghouse on Oral Problems Related to HIV Infection and World Health Organization Collaborating Center on Oral Manifestations of HIV Infection, London, England

[Scientific Papers and Presentations Omitted from Appendix]

Declaration of Donald Wayne Marianos, D.D.S., M.P.H.

Executed on September 18, 1995

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Donald Wayne Marianos, D.D.H., M.P.H. declare that:

I hold a Masters in Public Health from Loma Linda University and a Doctor of Dental Surgery from the Indiana University School of Dentistry. From August 1989 to the present I have served as Captain in the United States Public Health Service ("USPHS") at the Centers for Disease Control and Prevention ("CDC"). From 1992 to the present, I have served as the Director of the Division or Oral Health.

During my tenure at the CDC, I have provided technical assistance to international, federal, state and local health organizations in the area of infection control and infectious diseases in dentistry. I have served as dental consultant to the various CDC centers and institutes on issues related to HIV/AIDS and dentistry. In addition, I have coordinated epidemiologic investigations involving dental health care workers with HIV/AIDS as well as prevention of HIV/AIDS transmission in dental care settings. I have assisted in the development and dissemination of professional educational materials for dentists.

Prior to coming to the CDC, I was the Chief of Dental Services at the USPHS Indian Health Service Hospital in Whiteriver, Arizona from September 1979 to August 1989. There I was the senior administrator of the hospital dental program and community based preventive dentistry program. In that capacity, I treated approximately patients whom I knew to have HIV/AIDS. When treating these patients, I did not utilize any infection control procedures other than those recommended by the CDC.

My education and professional experience are more fully set forth in my curriculum vitae, attached hereto.

I have read the following documents generated in this case:

A. Expert Report of Randon Bragdon, DMD

B. Infectious Disease Policy of Randon Bragdon, DMD

C. Expert Report of Sanford Kuvin, MS, MD, DTM & H

D. Expert Report of Deborah Greenspan, BDS, DSc

E. Expert Report of John Molinari, PhD

F. Expert Report of Donald Craven, MD

G. Deposition of Randon Bragdon, DMD

Based upon my education, experience and expertise I offer the following opinions in this case:

1. The mission of the CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. As the United States' prevention agency, we accomplish our mission by working with our partners throughout the nation and the world to: monitor health problems; detect and investigate health problems; conduct research to enhance prevention; develop and advocate sound public health policies; implement prevention strategies; promote healthy behaviors; and foster safe and healthful environments.

2. The human immunodeficiency virus ("HIV") is a human retrovirus and is the causative agent of the Acquired Immunodeficiency Syndrome ("AIDS"). HIV infection is transmitted by sexual contact with an infected individual, exposure to infected blood or blood products, or perinatally from an infected mother to infant during pregnancy, birth, or breast feeding. In the 14 years since HIV was first recognized, our understanding of the modes of transmission of the virus have consistently demonstrated that casual contact has not been associated with transmission.

3. Over the years, the CDC has recommended the use of infection control procedures to protect the health and safety of

both health care workers and patients. Since medical history and examination cannot reliably identify all patients infected with HIV or other bloodborne pathogens, blood and body fluids precautions should be consistently used for all patients. This approach is referred to as "universal precautions" and should be used whenever infection control procedures are implemented.

4. In 1986 the CDC issued Recommended Infection Control Practices for Dentistry. The 1986 recommendations established a common set of infection control strategies for reducing the possibility of transmission of hepatitis B virus (HBV), HIV, and other bloodborne pathogens in the dental setting. They emphasized: the medical history; use of protective attire and barrier techniques; handwashing; use and care of sharp instruments; proper disinfection and sterilization of instruments; decontamination of environmental surfaces, supplies, and materials; use and care of dental handpieces; handling of biopsy specimens; and disposal of waste materials.

5. In 1987 the CDC issued Recommendations for the Prevention of HIV Transmission in Health Care Settings, including dentistry. The 1987 recommendations consolidated and updated previous CDC recommendations for preventing HIV transmission health care settings, as well as, precautions for clinical and laboratory staffs. The precautions for dentistry developed in 1986 were summarized.

6. In 1993, the CDC issued revised Recommended Infection Control Practices for Dentistry. The 1993 document updates previously published CDC recommendations for infection control practices in dentistry to reflect new data, materials, technology, and equipment. When implemented these recommendations reduce the risk of disease transmission in the dental environment, from patient to dental health-care worker (DHCW), from DHCW to patient, and from patient to patient. Based on principles of infection control, the document delineates specific recommendations related to vaccination of DHCWs; protective attire and barrier techniques; handwashing and care of hands; the use and care of sharp instruments and needles; sterilization or disinfection of instruments; cleaning and disinfection of the dental unit and environmental surfaces; disinfection and the dental laboratory; use and care of

handpieces, anti-retraction valves, and other intraoral dental devices attached to air and water lines of dental units; single-use disposable instruments; the handling of biopsy specimens; use of extracted teeth in dental educational settings; disposal of waste materials; and implementation of recommendations.

7. No infection control procedures beyond the use of universal precautions are necessary when providing routine dental care to persons with HIV and AIDSI. The CDC does not recommend the use of infection control procedures beyond those cited in the Recommended Infection Control for Dentistry, 1993 for the provision of routine dental treatment to persons with HIV or AIDS.

8. I do not know of any dental clinic or hospital that treats patients with HIV/AIDS that utilizes the procedures outlined in Bragdon's expert report. Indeed, in my experience, the vast majority of hospital dental operatories are not even equipped with the engineering controls (e.g., negative air pressure and ultraviolet lighting) that Bragdon maintains must be utilized before treating a patient with HIV/AIDS.

9. No special expertise beyond that of a general dentist is required to provide routine dental care to a person with HIV or AIDS.

10. If dentists, including general dentists such as Dr. Bragdon, follow universal precautions in their practice, persons with HIV or AIDS or other blood-borne pathogens can be safely treated in private dental offices.

11. If a dentist follows universal precautions – including, specifically, the heat sterilization of dental instruments and handpieces – there is virtually no risk of patient-to-patient transmission of HIV.

12. There is no medical or scientific basis for treating all HIV-positive dental patients in a hospital setting. With respect to the routine practice of dentistry, hospitals do not offer "superior" methods of infection control. So long as universal precautions are properly utilized, the risk of Hiv transmission from an infected patient to DHCW or from infected patient to

uninfected patient is not reduced by providing treatment in a hospital setting.

13. As of December 31, 1994, the last date for which I am aware of accurate statistics, CDC was aware of 42 health care workers in the United States who have been documented as having seroconverted to HIV following occupational exposures to HIV. None of these are dental workers.

14. 36 of the 42 occupational exposures to HIV were due to percutaneous exposures. Studies indicate that the quantity of inoculum (amount) of blood, as well as the titer (quantity of HIV in the blood) of infectious agent in the source blood are to be among factors associated with the risk of HIV transmission after percutaneous exposure to HIV-infected blood. In a case-control study, a larger quantity of blood transferred was represented by larger gauge of hollow-bore needles (<18 gauge), deep injury, and presence of visible blood contamination on the device. In dentistry, available information indicates that exposure to blood involves smaller rather than larger quantities of blood identified in the case control study. This may help explain the fact that there have been no documented cases of occupational transmission of HIV to DHCW's.

15. To the beset of my knowledge, there has never been an incidence of patient to patient transmission of any blood-borne pathogen in the dental setting.

16. Despite the fact that probably over one billion dental procedures have been performed by over 250,000 dental health care professionals in the past fourteen years, and despite the fact that approximately 1,000,000 individuals in the United States are estimated to be infected with HIV, there has never been a documented case of HIV transmission from infected patient to dental health care worker, nor from infected patient to non-infected patient.

17. As of January 1, 1995, information about investigations of 64 HCWs infected with HIV, including 29 dentists and 4 dental students, was reported to the CDC. Evaluations of over 22,000 patients of these HIV infected HCWs failed to detect

any transmission of HIV from HCW to patient. These data are consistent with previous assessments that the risk of transmission from a HCW to a patient is very small.

18. To date the only case of HIV transmission from a HCW to patient remains that of a Florida dentist who was found to have transmitted HIV to 6 of his patients. The specific mechanism of transmission has not been identified and it is unlikely to be identified in the future. To my knowledge, no studies have determined if these transmissions were accidental or intentional.

19. There are inherent risks associated with the practice of dentistry. Well before the advent of HIV, DHCW's were at risk of acquiring occupationally a number of diseases, from the common cold to potentially lethal Hepatitis B and TB.

20. For example, HBV is much more infectious than HIV, and many people who are infectious for HBV do not know that they are infectious. Approximately 200 HCWs, including dentists, die annually as a result of occupationally acquired HBV.

21. Given the demonstrated efficacy of universal precautions, Dr. Bragdon's Infectious Disease Policy is simply not grounded in current science as regards treatment of patients with HIV or other bloodborne pathogens.

I hereby delcare under penalty of perjury that the foregoing information is true tot he best of my knowledge and belief.

Exeduted on 9/18/95

/s/ Dr. Donald Wayne Marianos
Centers for Disease Control
MCPS/DDPA
1600 Clifton Road, N.E.
Mail Stop F-10
Atlanta, Georgia 30333

AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS POSITION PAPER ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Preface

The Association recognizes the need to address a variety of issues related to AIDS and Infectious Disease in the OMS office. During the past year, the membership has expressed a need for clarification regarding government regulations, infection control practice as well as ethical, legal, and political issues. In addition, the Committee on Federal Governmental Affairs recommended that the Board of Trustees authorize a position paper providing a response to proposed guidelines from the federal Centers for Disease Control (CDC). At its June meeting, the board appointed a Task Force on AIDS, which met in August and produced a draft position paper on AIDS, as well as a member of recommendations for AAOMS programs and activities. The board reviewed the position paper and recommendations and approved their transmittal to the 1991 House of Delegates which adopted the position as outlined below.

It should be stressed that the position paper reflects the best advice to the membership available based on the current status of a variety of factors which have undergone rapid change and continue to do so. It is anticipated that both CDC and OSHA will be further refining the federal regulations that are presently in draft form. It is expected that the position paper will evolve over time as scientific evidence and professional considerations dictate.

The Association and its membership have responded to the growing epidemic by stressing the importance of education. Scientific programs have included presentations on the treatment of infectious diseases, as well as infection control techniques for the hospital and oral and maxillofacial surgery office.

It is the position of the AAOMS that an oral and maxillofacial surgeon (OMS) who is HIV seropositive must refrain from the clinical practice of oral and maxillofacial surgery, except as

permitted under applicable CDC guidelines.

The AAOMS will pursue, by all necessary means, measures to ensure the availability of disability insurance benefits and retirement benefits for those OMSs who discontinue the practice of oral and maxillofacial surgery as a result of HIV seropositive status.

A necessary adjunct to any policy statement or guidelines that the Association may adopt regarding AIDS and infection control is the timely and accurate dissemination of that information to the membership of the Association.

There will be regular communications with the membership through a special insert in the Digest. This will facilitate distribution of the House's actions and other government or public interest activities that are pertinent to members for use in their practices.

In addition, the board approved funding for development and publication of a patient information pamphlet on infection control in the OMS office. This will be made available for purchase by members as soon as possible and is intended to help answer patient inquiries on the subject.

It is recommended that OMS obtain the publication available from the ADA on infection control and compliance with federal requirements on hazardous material and waste disposal as a useful basis for sound practice. Information to this end is scheduled for dissemination to the Association's membership in the near future.

September 1991

Introduction

The American Association of Oral and Maxillofacial Surgeons (AAOMS) has developed this Position Paper to address issues of concern to the public and the dental specialty of oral and maxillofacial surgery. The AAOMS recognizes the myriad of issues related to Acquired Immune Deficiency Syndrome (AIDS) that involve public health, professional practice, ethics,

and legal aspects. This paper supersedes the 1988 AAOMS Board of Trustees Statement of AIDS.

The AAOMS acknowledges the scientific work of the Centers for Disease Control (CDC) and the National Institutes of Health (NIH) in investigating and reporting on AIDS. Scientific principles must be the basis for addressing the public health issues raised by the AIDS epidemic. Education of all Americans on the known aspects of AIDS is essential to establishing rational policy. Lack of understanding, which can produce unwarranted fear, must not be allowed to dominate consideration of public policy. Refusal by health care workers to treat AIDS patients or even suspected AIDS patients is as unwarranted as proposals for mandatory universal testing or criminal penalties for health care workers who are seropositive for the human immunodeficiency virus (HIV) and who treat patients.

The paramount concern of the AAOMS is to provide the highest quality of patient care in a safe manner. The protection of patients against the transmission of any infectious disease, such as hepatitis or the human immunodeficiency virus (HIV), has been a standard practice in the sterile barrier techniques developed by oral and maxillofacial surgeons and taught in dental schools. However, the need for precautions to prevent the transmission of an infectious disease is as important to surgeons and surgical staff as it is to patients. The data indicate that one health care worker transmitted the HIV to as many as five patients. This is the only reported transmission by a health care worker to patients. However, the CCD has identified at least 40 health care workers who have been infected with the HIV by treating patients. Clearly, surgeons and surgical staff, who perform exposure-prone invasive procedures must be able to take all necessary precautions. The CDC has stated that the characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site.

AIDS is an infectious disease, and should be treated as a public health issue.

AIDS is a public health issue of concern to patients and health care professionals, as well as the general public. The treatment of patients with AIDS by health care professionals has been complicated by fear and political reaction. To address the treatment of AIDS patients, it must first be understood that AIDS is a disease. The treatment of AIDS as an infectious disease should not be affected by any separate political determination regarding AIDS as a disability. The AAOMS supports the principle of guaranteeing equal access to care for all patients, including those with AIDS or any infectious disease. Restrictions on the ability to communicate vital information, such as a patient's HIV status, when referring to another practitioner, can negatively affect quality of care.

The AAOMS opposes discrimination by an oral and maxillofacial surgeon or office staff in treating patients.

Since 1988, the Association has taken the specific position that refusal to treat a patient because that patient has or may have an infectious disease such as AIDS is unethical. This obligation is placed on the practicing OMS as a condition of membership in the AAOMS. In turn, the OMS must clearly identify this responsibility to the office staff. Education on universal precautions and barrier techniques is the most effective means to dispel unwarranted fears among health care professionals and the public.

HIV Testing of Health Care Practitioners: The AAOMS does not support mandatory testing of health care workers; however, OMSs and surgical assistants should be aware of CDC guidelines and use scientific and clinical data to determine the appropriateness of testing for their HIV status.

The AAOMS does not support mandatory testing of health care workers or patients. The most effective means to prevent the transmission of the HIV in the health care setting is to scrupulously follow universal precautions and to educate health care workers and patients on proper barrier techniques. Because an individual can be unknowingly infected, even with testing, all invasive procedures should be performed with the

assumption that there is a risk of HIV transmission.

The AAOMS endorses the CDC guidelines, which provide that health care workers who perform exposure-prone invasive procedures have an ethical and moral obligation to know their HIV status. The AAOMS encourages CDC and NIH to investigate what constitutes an "exposure-prone invasive procedure," and to make any such data known to health care agencies and professional organizations. OMSs should use up to date scientific and clinical data to fulfill their obligation to the public regarding the HIV status of health care workers.

However, neither the public nor health care workers should rely on testing as an assurance of safety against HIV transmission. The current blood test detects the presence of antibodies produced by the human immune system to fight the virus, not the virus itself. The validity of the blood test is diminished by the lapse of time that can occur between a person being infected with the HIV and the production of antibodies that would be detected by the test. This time lapse could be as long as six months. Also, the test can produce false negative results.

Moreover, the test only shows status for the moment of the test. A surgeon can have a negative test result, and then be infected by the next patient treated. The negative test result is thus meaningless to future patients. This raises the issue of how frequently testing would have to be conducted to be effective. Because of the flaws inherent in testing, there is no frequency of tests that would increase the effectiveness of testing. Neither patients nor health care workers should rely on a false sense of security produced by testing as protection against the transmission of the HIV. Constant testing is impractical, and expensive, and would need to be accompanied by the availability of counseling.

HIV Testing of Patients: The AAOMS does not support mandatory HIV testing of patients, but supports the right of a doctor to know the status of a patient for medical considerations.

The AAOMS does not support mandatory HIV testing of patients, for the same reasons discussed above regarding health

care workers. However, a health care worker needs to know the medical status of a patient to determine the appropriateness of treatment. The right of a doctor to know the status of a patient should not be infringed by anything but medical considerations.

It is difficult to discuss infection control for diseases such as hepatitis B and AIDS when AIDS is complicated by designation as a disability, raising issues of discrimination in treatment. Effective professional health care requires a consistent application of public policy. There is no medical reason to single AIDS out from other infectious diseases. This principle should be respected by health care workers as well as public policy makers.

Because the early manifestations of AIDS are often in the oral region, OMSs may often be in a position to diagnose the disease. The determination of appropriate care, such as whether surgery for another condition is indicated or which antibiotic should be prescribed, requires that the OMS be able to establish the patient's medical status, including HIV status, by testing if necessary. Early diagnosis of any disease, including AIDS, is in the best interest of the patient. Treatment can begin immediately, which can positively affect health status, and the risk of transmission can be reduced.

GUIDE TO PUBLIC HEALTH PRACTICE: HIV AND THE DENTAL COMMUNITY

Association of State and Territorial Health Officials

Association of State and Territorial Dental Directors

October 1989

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This publication presents the recommendations of the Association of State and Territorial Health Officials and the Association of State and Territorial Dental Directors. The effort was supported, in part, by the Centers for Disease Control and the U.S. Food and Drug Administration. The content of this publication does not necessarily reflect the views of the U.S. Department of Health and Human Services, nor those of the participating organizations.

Additional copies of this publication can be obtained by contacting:

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1220 L Street, N.W.
Washington, D.C. 20005

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FOREWORD

The public health community has a unique responsibility in meeting the challenges presented by the human immunodeficiency virus (HIV). State and local health departments have worked to prevent the spread of HIV through testing, counseling, partner notification, and education programs, and they continue to work to meet the needs of those already infected with HIV. The dental community's responsibility regarding HIV lies in preventing transmission of the virus in the dental setting, through utilization of appropriate

infection control measures, and in treating those infected with HIV.

This report presents official policies and recommendations on HIV and the role of the dental community that were formulated by the Association of State and Territorial Health Officials (ASTHO) and the Association of State and Territorial Dental Directors (ASTDD).

Appendix A contains a model questionnaire for use by state health departments and their dental programs in assessing the HIV-related knowledge, attitudes, and practices of dental health care workers. It will be particularly helpful to state health departments in targeting HIV and infection control education efforts for dental health care workers.

Appendix B presents a discussion of current practices in disinfection and sterilization of dental equipment and devices with respect to transmission of HIV. This section also contains recommendations for reducing the risk of transmitting HIV and other bloodborne pathogens in the dental setting, as well as a summary of the current information on the cost of infection control.

We want to thank all those who participated in the *Forum on HIV Prevention and Infection Control for the Dental Health Community*. Their experience and insights contributed greatly to the development of this report. Special thanks go to members of the Work Group for lending their time and expertise to this project. Unique contributions were also made by Dr. Nelson Moyer, Dr. Jeffrey Rosenbaum, and Dr. Barbara Gerbert.

Comments from readers would be appreciated as an indication of the need for expanding or revising the recommendations. Please address comments to the Public Health Foundation, 1220 L Street, N.W., Washington, D.C. 20005.

H. Denman Scott, M.D
President
ASTHO

William Maurer, D.D.S.,
M.P.H., President
ASTDD

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GUIDE TO PUBLIC HEALTH PRACTICE: HIV AND THE DENTAL COMMUNITY

I. INTRODUCTION

A. The Role of State Health Agencies in HIV Control

Since the identification of the human immunodeficiency virus (HIV), state health agencies (SHAs) have been directly involved in preventing the spread of HIV and in implementing treatment interventions. State health agencies' HIV risk reduction programs include comprehensive disease surveillance activities and widespread testing, counseling, treatment, and education services. SHAs have focused on reducing public misunderstanding about HIV and on securing a broad, articulated community consensus on public health programs for combating HIV. [Footnote 1] Scott, H. Denman, M.D., M.P.H., "AIDS Control From a State Health Department Perspective." Testimony before the Presidential Commission on the Human Immunodeficiency Virus Epidemic. March 1, 1988, Washington, D.C. [end Footnote 1]

Most SHAs have developed plans to slow the spread of HIV and to care for those infected with the virus. The scope of the plans varies widely and most do not include comprehensive strategies for use by state dental health programs in dealing with the epidemic. It is clear, however, that dental health care workers (DHCWs) have an important role to play in reaching the goals of state HIV Centers for Disease Control (CDC), dental health care workers are persons whose activities involve contact with patients or with blood or other body fluids from patients in a dental health care setting. [Footnote 2] "Recommendations for Prevention of HIV Transmission in Health-Care Settings," *Morbidity and Mortality Weekly Report.* Centers for Disease Control, August 21, 1987, Vol. 36, No. 2S, p. 3S. [end Footnote 2]

B. The Dental Community and HIV Control

Dental health care workers play a major role in the early diagnosis, treatment, and referral of HIV- infected individuals for additional health care and counseling, as well as in the provision of routine dental care and infection control. [Footnote 3] Statement of Vincent C. Rogers, D.D.S., M.P.H., for the American Dental Association to the Presidential Commission on the Human Immunodeficiency Virus Epidemic. January 14, 1988, Washington, D.C. [end Footnote 3]

A study of people with or at risk for HIV infection found that one-third of the study group exhibited oral manifestations of HIV infection. [Footnote 4] Silverman, Sol, Jr., M.A., D.D.S., et al., "Oral Findings in People With or at Risk for AIDS: A Study of 375 Homosexual Males," *Journal of the American Dental Association.* February 1986, Vol. 112, p. 189. [end Footnote 4] The oral manifestations of HIV infection include, among others, Kaposi's sarcoma, severe oral herpes simplex, gingivitis, oral candidiasis, oral warts, oral hairy leukoplakia, HIV periodontitis, and atypical mycobacterial infections. In addition, dentists also may detect cervical lymphadenopathy and other head and neck manifestations which occur in approximately 95 percent of patients with HIV infection. [Footnote 5] Richards, J.M., "Notes on AIDS," *The British Dental Journal.* March 23, 1985, p. 200. [end Footnote5]

HIV often results in multiple and overwhelming opportunistic infections. The virus is spread by sexual contact or sharing needles with infected individuals, and, less commonly, through transfused blood and blood products. The virus also may be transmitted from infected mother to infant during pregnancy or birth, or shortly after birth, most likely through breast milk. [Footnote 6] *Facts About AIDS.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control. Spring 1987, p.1. [end Footnote 6]

Dental health professionals who do not take proper precautions may be at risk for contracting saliva and bloodborne viral diseases, including hepatitis B (HBV) and HIV. [Footnote 7] "Infection Control in the Dental Office: A Realistic Approach." Interview with Charles H. Boozer, D.D.S., *Journal of the American Dental Association.* April 1986, Vol. 112, p. 463. [end Footnote 7] CDC estimates that there are nearly 1 million carriers of HBV in the United States and that up to 1.5 million Americans may carry HIV. In many cases, infected individuals are asymptomatic; therefore, dental health care workers, as well as the patients themselves, may be unaware of the patients' HBV and HIV seropositive status. Although HBV carries with it a higher risk of transmission than does HIV, it has not created the fear and stigma that have been associated with HIV.

A number of studies suggest that many DHCWs lack basic knowledge about treating HIV-infected patients. A study conducted at the University of California at San Francisco School of Dentistry found that only 57 percent of dental health professionals believed they had the skills needed to treat HIV patients safely and 75 percent preferred to refer persons at risk for HIV to other practitioners. [Footnote 8] Gerbert, Barbara, Ph.D., "AIDS and Infection Control in Dental Practice: Dentists' Attitudes, Knowledge, and Behavior," *Journal of the American Dental Association.* March 1987, Vol. 114, p. 312. [end Footnote 8]

A study released by the American Dental Association (ADA) found that only 31 percent of dentists were willing to treat HIV-infected patients, although 73 percent were willing to treat patients with HBV, which has a higher risk of transmission in the dental setting. In addition, only 5 percent of the dentists

believed that a private dental office was the best place to treat an HIV-infected patient. [Footnote 9] Verussio, A. Carl, Ph.D., et al, "The Dentist and Infectious Diseases: A National Survey of Attitudes and Behaviors," *Journal of the American Dental Association.* May 1989, Vol. 118, p. 560. [end Footnote 9]

Despite these findings, there is also good news. Researchers at the University of California at San Francisco reported that education programs are effective in improving dentists' attitudes about treating HIV-infected patients. A demonstration education program they conducted resulted in the participating dentists becoming more knowledgeable about HIV. They were also more willing to treat persons with HIV and to carry out a complete examination inside the mouth and external head and neck area. [Footnote 10] Gerbert, Barbara, Ph.D., et al, "Changing Dentists' Knowledge, Attitudes, and Behaviors Relating to AIDS: A Controlled Educational Intervention," *Journal of the American Dental Association.* June 1988, Vol. 116, No. 7, p. 851. [end Footnote 10]

A number of organizations, including CDC and ADA, have issued guidelines, using HBV as the model, for preventing the transmission of infectious diseases in dental settings. Although there are still many dental professionals who do not follow these guidelines, recent surveys suggest progress is being made. For example, in following a 1986 survey, the ADA found that the number of dentists who reported wearing gloves with every patient more than tripled in two years, rising from 23 percent of the survey respondents in 1986 to 76 percent of those responding in 1988. [Footnote 11] Verussio, A. Carl, Ph.D., et al, "The Dentist and Infectious Diseases," p. 555. [end Footnote 11] More improvements can be anticipated as DHCWs comply with the federal Occupational Safety and Health Administration (OSHA) requirements for worker protection against infectious agents.

C. The Role of State Health Agency Dental Programs in HIV Control

State dental health programs are charged with the responsibility of ensuring, promoting, and protecting the oral health of the public through organized community-based

activities. To this end, they are responsible for assessing the oral health needs of the public, and for developing and implementing plans for the prevention and control of dental diseases.

With respect to HIV, it is important that the directors of state health agencies clearly establish the role DHCWs have in controlling the spread of the HIV epidemic through early detection of oral manifestations of HIV, practicing appropriate infection control procedures, and patient counseling. Direct collaboration between state dental health programs and state HIV programs on all matters relating to the role of DHCWs in controlling the spread of HIV is important in limiting the HIV epidemic.

II. PROGRAM PLANNING

After a two-year study on the status of public health programs in the United States, the Institute of Medicine released a report containing recommendations for improving the U.S. public health system. Among the recommendations was a charge to SHAs to: assess the health needs within the state; establish statewide health objectives; and assure appropriate statewide efforts to develop and maintain personal and educational health services, provide access to necessary services, and solve problems inimical to the public's health. [Footnote 12] *The Future of Public Health,* Institute of Medicine. National Academy Press, Washington, D.C., 1988, p. 143. [end Footnote 12] ASTHO and ASTDD believe that similar recommendations for state dental health programs will serve to improve public understanding and access to dental health services in light of the growing challenge presented by the HIV epidemic.

ASTHO and ASTDD recommend the following:

> State dental health programs should develop and implement plans for monitoring the needs of HIV-infected individuals in the dental setting, as well as the needs of DHCWs with respect to HIV. The plans should assess the ability of current programs and resources to meet those needs in order to facilitate development of specific goals and objectives.

Program evaluation should result in development of appropriately targeted patient care services, educational programs for the public and health professionals, safety and infection control programs, and policies such as those related to confidentiality of medical information. The Centers for Disease Control should provide guidance to SHAs in the development of such programs.

Future program evaluations should address the achievement of previously defined goals and objectives and the establishment of new goals.

State dental health programs should identify training and educational needs of DHCWs through the use of knowledge, attitude, and practices (KAP) surveys. This information should be used to target education efforts. The HIV-related KAPs of DHCWs should be monitored over time to evaluate the effectiveness of education efforts.

III. EDUCATION

Education is the first line of defense in the fight against HIV infection. Widespread public and professional education about HIV is the most effective way to prevent transmission of the virus, to stop HIV-related discrimination, and to assure access to health care. A recent study indicates that educational interventions that acknowledge dentists' fears and concerns, while addressing their knowledge and behavioral gaps, can be effective in enhancing the response of dentists to the HIV epidemic. [Footnote 13] Gerbert, Barbara, Ph.D., et al., "Controlled Educational Intervention," pp. 851-854. [end Footnote 13]

ASTHO and ASTDD recommend the following:

State dental health programs should assist in ensuring that all DHCWs are knowledgeable about HIV infection and related subjects so they can provide competent care and accurate information to patients and can prevent

unnecessary risk to themselves, their staff, and their patients.

Appropriately trained DHCWs should:

Understand the epidemiology of HIV and other infectious agents;

Be able to identify oral manifestations of HIV;

Recognize appropriate situations in which to refer patients to other health care providers;

Develop and implement appropriate patient management plans;

Know how to access HIV-related information and services;

Be familiar with confidentiality and discrimination laws in their jurisdiction;

Adhere to current federal, state, and local regulations and guidelines on infection control;

Be aware of their responsibility to treat individuals with HIV;

Implement proper management of medical waste; and

Be able to educate their patients about HIV risk factors and modes of transmission.

State dental health programs should work in collaboration with CDC and other federal agencies, local health departments, state AIDS coordinators, professional associations, AIDS Education and Training Centers (ETCs), state dental licensing boards, dental and allied dental schools, and private providers, to develop and provide continuing education on HIV-related issues to DHCWs.

State dental health programs should coordinate efforts with state dental licensing boards to ensure that dental professionals avail themselves of continuing education related to infection control and bloodborne diseases, including HIV. This should be done by requiring continuing education credits in these areas as a condition for maintaining licensure. These licensure requirements should be consistent with state requirements.

State dental health programs should work with Schools for DHCWs to integrate appropriate material about HIV into their curricula to ensure that all students are educated about infection. Dental schools should provide and encourage HIV-related research and their experiences.

SHAs should include in their public education programs accurate information to diminish irrational fears about transmission of HIV through dental treatment.

SHAs should work with the private dental community to encourage all dental offices to offer literature about HIV and infection control procedures used in their offices. In explaining the use of infection control procedures, DHCWs can both educate their patients and reassure them that their visit does not place them at risk of infection.

IV. ORAL HEALTH CARE MANAGEMENT OF HIV-INFECTED PATIENTS

Many DHCWs have responded quickly to the need to provide high quality dental care to HIV infected persons. However, many barriers to appropriate treatment still exist. Recent surveys of dentists have identified some of the major attitudinal barriers to caring for people with HIV infection. These include the dentists' fear of contracting HIV from patients and fear of losing other patients. Dentists also anticipate problems with their staff and some believe they lack skills necessary to treat HIV-infected individuals. Some dentists feel that by excluding patients with known HIV infection they will keep their practice free from HIV. This misconception has led some dentists to discontinue treatment of patients with HIV infection. [Footnote 14] Raper, P.E., "AIDS: Prevent Its Spread, Treat Its Victims," *Dentistry Today*. 1985, Vol. 4, No. 8, pp. 1, 21. [end Footnote] However, because asymptomatic patients who are infected with HIV may not disclose or may be unaware of their HIV status, it is not possible to selectively exclude HIV-infected patients from dental practices.

A. Access to Care/Duty to Treat

Improving access to health care is one of the greatest challenges facing the nation's health care system today. While access to appropriate health care remains a problem for many Americans, HIV-infected persons face sometimes insurmountable barriers in securing and maintaining health insurance coverage and in finding health care providers willing to treat them.

All DHCWs have an ethical, professional, and, in most cases, legal obligation not to engage in discrimination in their decisions to treat patients. Although a dentist has the right not to accept a new patient for treatment when no immediate emergency exists, a dentist may not refuse to accept a new patient because of that person's race, gender, ethnicity, or, in some state/localities, sexual orientation and/or disability. [Footnote 15] Logan, Mary, J.D., "Legal Implications of Infectious Disease in the Dental Office," *Journal of the American Dental Association*. December 1987, Vol. 115, p. 853. [end Footnote 15]

The federal government, as well as many states and municipalities, have ruled that HIV-related conditions (including the presence of HIV antibodies) are handicaps protected by existing handicapped discrimination laws. [Footnote 16] Ibid. [end Footnote 16] Recipients of federal funds, which arguably may include dentists who accept Medicaid and Medicare, are also subject to these statutes. [Footnote 17] Ibid. [end Footnote 17]

ASTHO and ASTDD recommend the following:

> DHCWs have an ethical obligation to provide dental care to HIV-infected individuals, or those perceived to be at risk of HIV infection, in the same manner as they would to other patients.

In some instances, referral to dental specialists for HIV-related problems may be required, but such referrals should be limited to specialized procedures normally referred to other health care providers. (See Section IV.C.) HIV seropositivity is not sufficient cause for referral.

B. Diagnosis and Treatment of HIV-Associated Conditions by DHCWs

Because oral lesions may be an early indication of HIV infection and such oral manifestations occur in approximately one-third of those infected with HIV, a DHCW, in many cases, may be the first health care provider to observe evidence of HIV infection in a patient. Therefore, DHCWs must be able to recognize the oral manifestations of HIV infection.

ASTHO and ASTDD recommend the following:

Every dental patient should have a complete oral health history taken and be given thorough oral examination, including the head and neck.

Consistent with usual practices, each patient's health history should be updated regularly and appropriate notes made in the patient's chart.

If a DHCW finds evidence of oral manifestations of HIV infection, the DHCW should update the patient's history to include detailed information on general health status, any observed oral signs and symptoms, and a recommendation that a primary health care provider evaluate the patient's immune status.

The DHCW should be aware of the confidentiality of information regarding HIV status. Entries made in the written health history should be consistent with current legal and ethical standards.

Counseling, testing, and diagnosis of HIV-infected individuals are the responsibility of the primary health care provider or SHA counseling and testing services. If a

patient with suspected HIV infection does not have a primary health care provider, the DHCW should assist the patient in locating necessary services.

All DHCWs should give patients, including HIV-infected patients, the opportunity to express treatment preferences as early as possible after diagnosis. Such opportunities help to maintain an individual's sense of self-worth and personal dignity.

DHCWs involved in direct patient care have a need to know relevant HIV-related patients information which might assist them in the treatment and care of patients.

C. Referral To and From Other Health Care Providers

ASTHO and ASTDD recommend the following:

Treatment and management of oral manifestations of HIV infection should take place in close collaboration with the patient's primary health care provider. The primary health care provider should be encouraged to consult with a dentist who is participating in the patient's overall health care management.

The diagnosis or suspicion of HIV infection is not sufficient cause for referral to another health care provider. Consistent with usual practices, referrals of HIV-infected patients to another dentist, facility, or primary care provider should be made when the primary dentist has the need of another's skills, knowledge, equipment, or experience. A referral should also be made if the dentist determines, after consultation with the patient's primary health care provider, that the patient's health would be significantly compromised by the provision of dental treatment. [Footnote 18] *ADA Principles of Ethics and Code of Professional Conduct,* American Dental Association. July 1988, p.2. [end Footnote 18]

When referrals are necessary, dentists should communicate clearly with their patients about the referral to avoid frustrating and confusing the patients or undermining their

confidence in the care provided. DHCWs should encourage patients' questions and provide answers about the referral as a way to alleviate some of the fears associated with unfamiliar treatments or providers. [Footnote 19] Ibid., p. 600. [end Footnote 19]

DHCWs should know how to gain access to other services for HIV-infected patients. These services may include medical, legal, and psycho-social components. SHAs and their dental programs should work with private dental associations and local health departments to make this information readily available.

D. Overcoming Financial Barriers to Treatment

Individuals with HIV infection often face financial barriers to health services, including dental treatment. In many cases, a person with HIV-related illness loses income and insurance coverage due to his or her inability to work. In addition, it is very difficult for HIV-infected persons who are uninsured to obtain health insurance coverage due to restrictions regarding pre-existing conditions.

To date, most known cases of HIV infection have occurred in single males, yet this group receives the lowest priority in determination of medical indigence in state Medicaid program eligibility guidelines. [Footnote 20] Statement of Vincent C. Rogers, D.D.S., M.P.H., for the American Dental Association to the Presidential Commission on the Human Immunodeficiency Virus Epidemic. January 14, 1988, Washington, D.C. [end Footnote 20] Many people with HIV infection eventually become Medicaid eligible; however, insufficient provider reimbursement levels, as well as excessive paperwork, delayed reimbursement, and other inconveniences, make it increasingly difficult to locate dentists willing to treat Medicaid patients. Some states do not cover adult dental benefits, and others limit adult dental benefits to emergency care only. Currently, Medicare benefits do not include coverage for routine dental health care services.

ASTHO and ASTDD recommend the following:

State and local governments should work with the federal government to identify methods for improving access to dental care for HIV-infected individuals within the Medicaid program. These methods may include expanding eligibility criteria, expediting coverage, improving reimbursement rates, and expanding covered dental services, perhaps through utilization of Medicaid waivers.

Care for HIV-related oral problems should be covered under dental, medical, and health insurance plans.

V. SAFETY AND INFECTION CONTROL

A. Procedures for Infection in the Dental Setting

Implementing current standards of infection control is necessary to ensure the safety of both DHCWs and patients. DHCWs can reduce the risk of HIV transmission in dental settings by following the infection control procedures recommended by CDC and ADA for infectious bloodborne diseases.

Infection control measures, as recommended by CDC and ADA and as required by OSHA, are effective in reducing the risk of transmitting infectious agents, including HIV. All health facilities, including dental offices, are required to meet OSHA standards for worker protection from infectious agents. These standards include office infection control programs and worker training and education. OSHA requires DHCWs to use barrier techniques with all patients to reduce the risk of transmitting bloodborne infectious disease like HBV and HIV. In addition, all dental offices are subject to inspections by OSHA.

Part of an effective infection control program includes immunization of DHCWs with the HBV vaccine. The HBV vaccine is widely available and is highly effective against HBV. Its use by DHCWs has been strongly urged by CDC. [Footnote 21] "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B, and Other Bloodborne Pathogens in Health-Care Settings," *Morality Weekly Report.* Centers for Disease Control. June 24, 1988, Vol. 37, No. 24, p. 1. [end Footnote 21]

ASTHO and ASTDD recommend the following:

> State and local dental health programs and professional dental associations should collaborate to ensure that all DHCWs adhere to universal precautions and employ appropriate infection control procedures at all times. Because it is not feasible for DHCWs to confirm the HIV status as well as the status of other infectious bloodborne diseases for all patients, infection control procedures should be implemented as though each patient were potentially HBV- and HIV-infectious.
>
> Employers of DHCWs have an obligation to ensure that necessary infection control equipment and supplies are available and that all workers are adequately trained in their use, in accordance with existing federal and state regulations and guidelines. Documentation of infection control procedures used in the office and a record of the training for each staff member should be maintained, consistent with OSHA guidelines.
>
> State dental health programs and private dental organizations should work together to ensure that dental offices have policy statements in place regarding exposure of employees to blood and body fluids, in order to ensure appropriate medical care, follow-up, and monitoring. [Footnote 22] *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic.* June 1988, p. 34. [end Footnote 22]
>
> Dental employers should offer to provide the HBV vaccine for employees involved in direct patient care.
>
> Medical waste should be handled and disposed of in accordance with federal, state, and local laws and regulations.

B. The HIV-Infected Dental Health Care Worker

Experts on infection control have reported that there is minimal risk of harm to patients when an HIV- or HBV-infected DHCW performs invasive procedures, as long as the DHCW uses

recommended barrier techniques. [Footnote 23] Logan, Mary, J.D., "Legal Implications," p. 852. [end Footnote 23]

ASTHO and ASTDD concur with CDC recommendations regarding the management of HIV-infected health care workers:

> DHCWs with impaired immune systems should be counseled about the potential risk to themselves of treating patients who have transmissible infections and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents.
>
> The adequate and safe treatment of patients by an HIV-infected DHCW must be determined on an individual basis. These decisions should be made by the DHCW's primary care physician. [Footnote 24] "HIV Transmission Recommendations," *Morbidity and Morality Weekly Report,* p. 16S. [end Footnote 24]

ASTHO and ASTDD also recommend the following:

> HIV-infected DHCWs should be encouraged to practice for as long as they are able to perform their duties safely and competently.
>
> DHCWs should be aware of and follow current laws and regulations regarding the treatment of patients by health care workers with infectious diseases.

VI. CONFIDENTIALITY OF HEALTH INFORMATION

Ensuring confidentiality of HIV-related information is critical to maintaining and promoting public confidence in the health care delivery system. Protecting the confidentiality of public health and medical records is both a legal and ethical duty. Because reported or feared breaches of confidentiality may result in actual or perceived HIV-related discrimination, such breaches discourage individuals from learning their HIV status. Without adequate confidentiality protection, it is difficult to ensure that people are counseled on how to prevent HIV transmission and that they are provided appropriate health care services.

ASTHO and ASTDD define HIV confidentiality as "the protection from release of information, without the consent of the named party, which links the individual's identity to facts about HIV seropositivity, behavioral risk factors, or application for related services. Disclosure of information without documented consent of the individual is permitted only when the disclosure is necessary for the individual's medical care, or is required by law." [Footnote 25] *Guide to Public Health Practice: AIDS Confidentiality and Anti-Discrimination Principles,* Association of State and Territorial Health Officials, March 1988, p. 5. [end Footnote 25] This definition also applies to dental care.

In addition, testing without counseling, as well as testing as a means for excluding patients from treatment, is unethical. Testing must always be: (1) accompanied by the documented informed consent of the person being tested; (2) strictly confidential, except when disclosure is necessary for the individual's medical and dental care, or is allowed or require by law, (3) done in conjunction with adequate pre- and post-test counseling; and (4) done in accordance with state laws. [Footnote 26] Ibid., p. 6. [end Footnote 26]

ASTHO and ASTDD recommend the following:

> State dental health programs should collaborate with professional dental associations to develop model policies consistent with the confidentiality laws in their states to assure that medical/dental information is collected and managed to ensure confidentiality.
>
> SHAs should work through their dental programs, and in collaboration with professional dental associations and state dental associations and state dental licensing boards, to ensure that DHCWs are familiar with the confidentiality and medical records laws in their jurisdictions before transferring patient information to other health care providers. DHCWs should understand the potential consequences both to the patient and the DHCW of breaches of confidentiality.

> Dentists should obtain the patient's permission before forwarding health records that contain information concerning HIV status or consulting with another dentist or physician when circumstances do not permit patient anonymity. [Footnote 27] Ibid., p. 7. [end Footnote 27]
>
> The dentist is responsible for approving the release of HIV-related information to another dentist or physician that is necessary for treatment.
>
> An authorization for disclosure of HIV-related information must be documented except where disclosure is authorized by law. Although state laws vary, the authorization should, in general, specify to whom the information will be disclosed, how the information will be used, and the time period during which the consent will remain valid. Patients should be advised of their right to refuse authorization without threat of discrimination. Further, patients should be advised of the potential consequences, including discrimination, of voluntarily revealing their HIV antibody status to others when not necessary.
>
> Because an individual's dental record may include confidential information, including HIV status, all patient records should be accessible to only to persons authorized by the dentist as part of patient care. Policies to maintain confidentiality should be established and adhered to in all dental settings.

AADS REVISED POLICY STATEMENT III B, AS AMENDED BY THE AADS HOUSE OF DELEGATES, MARCH, 1993, CHICAGO, ILLINOIS

Infectious Diseases. Dental education has the obligation to maintain standards of health care and professionalism that are consistent with the public's expectations of the health professions.

1. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.

2. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or hepatitis B infection. These patients must not be subjected to discrimination.

3. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.

4. The dental education institution is ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious disease. Dental personnel who pose a risk of transmitting an infectious disease must consult with appropriate health-care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer of the dental education institution should take steps consistent with the advice of appropriate health-care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any professional activity that would create a risk of transmission of the infection to others. In addition, the chief administrative officer of the institution must facilitate appropriate counseling and follow-up care, and should consider establishing retraining

and/or counseling programs for those faculty, staff, and students who do not continue to perform patient care procedures. Dental education institutions should make institutional guidelines and policies in this area available to current and prospective students, staff, and faculty.

5. Chief administrative officers of dental education institutions must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous-waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines and must be provided to all faculty, students, and appropriate support staff. To protect faculty, students, staff, and patients from possibility of cross-contamination and infection, asepsis protocols must include policy requiring the availability and use of gloves, masks, and protective eye wear by faculty, staff, and students in both preclinical and clinical situations.

6. Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should (1) demonstrate proof of immunity, (2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or (3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but other infectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions should require pre-matriculation and annual testing for tuberculosis.

***

…. dental personnel to meet dentistry's responsibilities to the public.

D. Research, clinical trials, and demonstration projects that are supported in part or in whole by commercial and other extramural sources.

1. The AADS encourages dental education institutions and dental educators to interact with commercial and other extramural sponsors of research, clinical trials, and demonstration projects under conditions in which the academic rights of faculty are protected. These conditions include rights of publication, ownership of intellectual property, and rights of patent and copyright within institutional policy, subject to appropriate contractual protection of the sponsor's legitimate interests.

2. The AADS encourages publication by faculty of the results of research, clinical trials, and demonstration projects supported by commercial and other extramural sponsors.

a. Peer review by scientists/educators with expertise in the relevant field(s) of the research or project is the best means of assuring quality of the publication.

b. The AADS discourages submission of manuscripts to any publisher that allows sponsors of the work to influence editorial policy or judgment after the completion of the peer review process.

III. Delivery of Care
A. Objectives

1. The public need and demand should be the criteria for the number and kind of practitioners educated. The actual needs and demands of the public as well as the number and kind of practitioners who can accommodate those needs and demands should be revevaluated. Analysis of those needs and demands should be constantly monitored so that dental education institutions do not overproduce or underproduce members of the dental team in a given area. Dental education institutions should provide extramural experiences for their

students in various community settings.

2. The responsibilities of the dental team should be redefined. In the process, care should be taken to ensure career satisfaction of those to be affected.

3. Dental education institutions should emphasize the importance of the dentist's social responsibility as well as new modes of practice which will assure improved quantity and quality of dental care.

4. Dental schools are encouraged to use stated criteria and demonstrated competencies as the primary basis for, and judgment of, student performance.

5. Chief administrative officers of dental education institutions should consider appointing a collegiate safety officer who is responsible for all radiation sources within the dental school. If a university radiation officer exists, the collegiate radiation officer should be subject to general university regulations.

6. Patients seeking treatment in an educational institution should be made aware of the scope of services available at that institution, should have the opportunity to agree to a treatment plan, should be provided with an estimate of the cost of treatment, and should be informed of any limitations to therapy. Patients accepted for treatment should receive the indicated therapy according to a properly sequenced treatment plan. The time between the screening assessment and the assignment for appropriate care should be kept to a minimum.

III. Delivery of Care
B. Infectious Diseases.

Dental education has the obligation to maintain standards of health care and professionalism that are consistent with the public's expectations of the health professions.

1. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.

2. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or hepatitis B infection. These patients must not be subjected to discrimination.

3. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.

4. The dental education institution is ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious disease. Dental personnel who pose a risk of transmitting an infectious agent must consult with appropriate health-care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer of the dental education institution should take steps consistent with the advice of appropriate health-care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any professional activity that would create a risk of transmission of the infection to others. In addition, the chief administrative officer of the institution must facilitate appropriate counseling and follow-up care, and should consider establishing retraining and/or counseling programs for those faculty, staff, and students who do not continue to perform patient care procedures. Dental education institutions should make institutional guidelines and policies in this area available to current and prospective students, staff, and faculty.

5. Chief administrative officers of dental education institutions must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous-waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines, and must be provided to all faculty,

students, and appropriate support staff. To protect faculty, students, staff, and patients from the possibility of cross-contamination and infection, asepsis protocols must include policy requiring the availability and use of gloves, masks, and protective eye wear by faculty, staff, and students in both preclinical and clinical situations.

6. Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should (1) demonstrate proof of immunity, (2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or (3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but other infectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions should require pre-matriculation and annual testing for tuberculosis.

III. Delivery of Care
C. Dental Health Personnel

1. The American Association of Dental Schools makes the following statements concerning the current dental health personnel situation.

Dental schools are important national, regional, state, and community resources.

Dental schools are providers of scientific research, predoctoral and postdoctoral and allied dental education, as well as continuing education for the practicing profession, and are

providers of comprehensive dental care for those otherwise underserved.

Dental schools are a vital component of the health sciences segment of universities.

Major reductions have been made in dental school enrollment levels nationally in response to the changing size of the personnel and applicant pools and demand for care.

Continued and haphazard reduction of dental school enrollment levels may result in a personnel supply that is inadequate to meeting the dental care demands of the changing population in the United States within the next two decades. Such an unfortunate situation would result in a costly effort to restore this valuable resource to adequate size. Further, it would compromise the ability to positively address and overcome the current inadequate representation of minorities and women in the practicing profession.

Therefore, the AADS believes that further reductions in first-year dental school enrollments are not in the public interest. The Association commits itself to monitor the changing environment in which dental schools operate and dentists practice, and to review and adjust its policy regarding dental school enrollment as indicated.

III. Delivery of Care
D. Licensure and Certification

1. The American Association of Dental Schools should cooperate with the American Dental Association, the American Dental Hygienists' Association, and the American Association of Dental Examiners to develop uniform standards for licensure and credentialing that would permit freedom in geographic mobility for dentists and dental hygienists.

2. The Association should explore the medical-legal and infection-control liabilities and the ethical issues associated with the delivery of care in clinical entry-level board examinations.

3. The Association, in cooperation with appropriate

organizations and agencies, should identify the minimum competencies needed by dental personnel to participate effectively in the delivery of health care.

4. The Association, both through cooperative venture and on its own initiatives, should support the development of valid and reliable methods that can be used nationally to measure minimum competencies of dental personnel.

5. The Association, in cooperation with appropriate organizations and agencies, should explore the development of alternative testing methods, and support the development of appropriate demonstration projects and pilot programs.

6. The American Association of Dental Schools, in cooperation with appropriate agencies, should work diligently toward eliminating the use of human subjects in entry-level examinations.

7. As a long-term goal, the Association recommends elimination of state and regional entry-level clinical licensure examinations for dentists and dental hygienists who are graduates of programs accredited by the Commission on Dental accreditation, and have successfully completed the National Board Dental Examinations or the National Board Dental Hygiene Examinations.

DEFENDANT RANDON BRAGDON, D.M.D.'S RESPONSE TO PLAINTIFF'S REQUEST FOR ADMISSIONS

(dated 04/13/95)

(Caption omitted in printing)

1. From at least since 1980 continuously through the date of answering these requests for admission, Bragdon has been the sole owner of a dental practice with an office located at 30 Judson Boulevard in Bangor, Maine.

RESPONSE: Admitted.

2. From at least 1980 continuously through the date of answering these requests for admission, Bragdon has established and controlled all of the operations, policies and procedures of the Bragdon Dental Practice.

RESPONSE: Admitted.

3. On September 16, 1994, Bragdon was the owner and operator of the professional office of a health care provider located at 30 Judson Boulevard in Bangor, Maine.

RESPONSE: Admitted.

4. During the calendar year 1994, the Bragdon Dental Practice did not have any limitations or restrictions on the patients it would accept based upon gender, age or geographical location of the patient.

RESPONSE: Admitted.

5. During the calendar year 1994, the Bragdon Dental Practice did not limit or restrict its services only to patients who were referred to the Bragdon Dental Practice by another dentist or health care provider.

RESPONSE: Admitted.

6. During the period 1990 through the date of answering

these requests for admission, the Bragdon Dental Practice had accepted as new patients individuals who called the Bragdon Dental Practice for an appointment after learning about the Practice from another patient of Bragdon or the Bragdon Dental Practice.

RESPONSE: Admitted.

7. During the period 1990 through the date of answering these requests for admission, the Bragdon Dental Practice had accepted as new patients individuals who did not know existing patients of Bragdon.

RESPONSE: Admitted.

8. On September 16, 1994, Bragdon was accepting new patients.

RESPONSE: Admitted.

9. From 1980 to the date of answering these requests for admission, the Bragdon Dental Practice has been listed in the Bangor area Yellow Pages.

RESPONSE: Admitted.

10. The document attached as Exhibit A to these requests for admission is a genuine, true and accurate copy of the "Infectious Disease Policy" of the Bragdon Dental Practice which was written by Bragdon.

RESPONSE: Admitted.

11. At all times during which the Infectious Disease Policy has been in effect, including September 16, 1994, and the date of answering these requests for admission, there have been no circumstances under which Bragdon would provide dental treatment in the Bragdon Office to a patient with HIV or AIDS.

RESPONSE: Admitted.

12. Bragdon does not intend to eliminate or revoke the

Infectious Disease Policy with respect to patients with HIV or AIDS.

RESPONSE: Admitted.

13. In the future, Bragdon does not plan to provide dental treatment in the Bragdon Office to patients with HIV or AIDS.

RESPONSE: Denied. Dr. Bragdon does not know what will happen in the future.

14. On September 16, 1994, filling a cavity was a dental procedure which was within Bragdon's realm of competence and the scope of services of the Bragdon Dental Practice.

RESPONSE: Defendant admits that filling a cavity was within his realm of competence and the scope of services of the Bragdon Dental Practice for patients free from infectious diseases. Defendant denies that filling a cavity at his Bangor office was within his realm of competence and the scope of services of the Bragdon Dental Practice for patients who were not free from infectious diseases.

15. The procedure for filling a cavity of an HIV-positive person does not require specialized training which is different than the procedure for filling the cavity of a patient who is not HIV-positive.

RESPONSE: Denied.

16. If Bragdon provides dental services to a patient with HIV or AIDS in a hospital surgical operatory rather than at the Bragdon Office, the patient, not Bragdon, must pay additional cost of the hospital surgical operatory.

RESPONSE: Admitted.

17. As of September, 1994, Bragdon understood the substance of and followed in the Bragdon Office all of the recommendations and requirements of the CDC, OSHA, and the American Dental Association to prevent the transmission of blood-borne pathogens, including HIV, in practice of dentistry.

RESPONSE: Denied. Dr. Bragdon admits that the assertions are true to the best of his knowledge.

18. As of September 16, 1994, Bragdon had not obtained privileges or credentials at any hospital or other institution to use a surgical operatory for the purpose of performing dental procedures or treatment on his private patients.

RESPONSE: Denied.

19. As of September 16, 1994, Bragdon had not applied to any hospital or other institution to use a surgical operatory for the purpose of performing dental procedures or treatment on his private patients.

RESPONSE: Denied.

20. On September 16, 1994, Sidney Abbott was present at the Bragdon Office for a previously scheduled appointment.

RESPONSE: Admitted.

21. On September 16, 1994, Bragdon learned that Ms. Abbott was HIV-positive which she disclosed in response to Bragdon's inquiry whether Ms. Abbott had any medical conditions.

RESPONSE: Denied.

22. On September 16, 1994, Bragdon determined that Ms. Abbott had a cavity which required a filling.

RESPONSE: Admitted.

23. On September 16, 1994, Bragdon told Ms. Abbott that he would not fill her cavity in the Bragdon office, but would fill Ms. Abbott's cavity in a hospital surgical operatory.

RESPONSE: Admitted.

24. On September 16, 1994, Bragdon told Ms. Abbott that

she would be responsible for the cost of the hospital surgical operatory referred to in request for admission number 23.

RESPONSE: Admitted.

25. Bragdon believes that the people who are HIV-positive in the United States are most likely to be gay men, people who use or have used intravenous drugs, and their sexual partners.

RESPONSE: Denied.

26. On September 16, 1994, Bragdon used a heat sterilization process to sterilize all nondisposable dental instruments which he ever places in a patient's mouth, including the high and low speed dental handpieces.

RESPONSE: Denied.

27. The process of heat sterilization kills all microbial life, including HIV.

RESPONSE: Denied.

28. CDC has not documented any case of transmission of HIV from a patient to a dental health care.

RESPONSE: Denied.

29. CDC has not documented any case of transmission of HIV from a patient to another patient in a dental setting.

RESPONSE: Admitted.

30. There is no documented or proven case of transmission of HIV through aeorsols. (sic)

RESPONSE: Admitted.

/s/ John W. McCarthy, Esq.,
Attorney for Randon Bragdon, D.M.D.

DEFENDANT RANDON BRAGDON, D.M.D.'S ANSWERS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES DATED MAY 4, 1995

[Caption Omitted in Printing]

The Defendant, Randon Bragdon, D.M.D., by and through his attorneys Rudman & Winchell, answers the Plaintiff's first set of interrogatories as follows:

1. Identify and describe in detail any circumstances under which Bragdon will provide dental treatment in the Bragdon office to a patient with HIV or AIDS.

ANSWER: None when the patient is known to be infected.

2. Describe how Bragdon's Infection Disease Policy operates and is implemented when a person with each of the follow infectious diseases presents at the Bragdon office for dental services or treatment: AIDS, HIV, Tuberculosis, Hepatitis A,B,D, and non A-B, measles and strep throat.

ANSWER: The defined patient groups are not knowingly treated in the office.

3. Describe in detail all infection control procedures employed by Bragdon in his dental practice on September 16, 1994, Bragdon's methods of sterilization of the high and low speed dental handpieces and other instruments, all types of protective wear worn by Bragdon and his staff (including the types and brand names of gloves, masks and protective eyewear), and the methods by which Bragdon disinfected or cleaned any aspect of the dental operatory after each patient visit.

ANSWER: The procedures are described in my blood pathogen standard program and the hazardous materials program. The documents are available in my office for review by plaintiff through counsel.

I cannot recall the names of the variety of brands of gloves, masks and protective eye wear utilized on September 16,

1994. I generally use latex examination gloves. I usually use ear loop protective masks. One employee uses Nitrile type protective gloves. We use prescription and nonprescription eye glasses with side shields.

4. Identify each hospital or institution at which Bragdon had obtained privileges or credentials to use a surgical operatory or other hospital space for dental procedures as of September 16, 1994.

ANSWER: I have obtained privileges in the past. I have performed dental functions at the Bangor Mental Health Institute. However, I did not have privileges at any institution where I could provide services as of September 16, 1994.

5. With respect to each hospital or institution identified in Interrogatory Number 4, state the date on which Bragdon was granted such privileges or credentials and the scope and nature of such privileges or credentials.

ANSWER: I believe I obtained privileges at Bangor Mental Health Institute in the early 1980's.

6. Identify each hospital or institution at which Bragdon has ever applied for privileges or credentials to use a surgical operatory (or other hospital space) for dental procedures, the date on which such application was made, and the results or current status of such application.

ANSWER: Boston City Hospital, 1977, approved for one surgery rotation. Togus Veterans Hospital, 1978, approved for externship. Bangor Mental Health Institute, early 1980's, approved for staff privileges. No notice of termination but operatory no longer maintained. Down East Community Hospital, 1994, pending.

7. If Bragdon did not have privileges or credentials to use a hospital surgical operatory (or other hospital space) as of September 16, 1994, state all facts and identify all documents upon which Bragdon relies to support his contention that he would have provided treatment to Abbott in a hospital surgical operatory.

ANSWER: If the plaintiff desired the services I would have worked with the patient and her physician and hospitals to secure a proper site for the dental care.

8. Specify and describe all medical, epidemiological, dental or scientific facts and evidence upon which Bragdon relies to justify his Infectious Disease Policy on the basis that there is an unacceptable risk of HIV transmission from an HIV-positive patient to another patient in the Bragdon office.

OBJECTION: Defendant objects to this interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, the Infectious Disease Policy is based on multiple publications, teaching and training. A disclosure of the documents which I have reviewed and which I rely on in developing, formulating, or implementing my Infectious Disease Policy will be made available at the convenience of all counsel at the offices of Rudman & Winchell, Bangor, Maine. I will also advance an expert position in accordance with the Federal Rules of Civil Procedure. Any expert will disclose documents relied upon in advancing the opinion as is required by the Federal Rules of Civil procedure.

9. Specify and describe all medical, epidemiological, dental or scientific facts and evidence upon which Bragdon relies to justify his Infectious Disease Policy on the basis that there is an unacceptable risk of HIV transmission from an HIV-positive patient to a dental worker in the Bragdon office.

OBJECTION: Defendant objects to this interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, please see answer to interrogatory number 8.

10. Specify and describe all medical, epidemiological, dental or scientific facts and evidence

(including the title and date of any journal article or other publication) upon which Bragdon relies for any contention that this Infectious Disease Policy with respect to patients with HIV or AIDS is necessary because HIV can be transmitted to a health care worker or another patient in the Bragdon Office through aerosols.

OBJECTION: Defendant objects to this interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, please see answer to interrogatory number 8.

11. Specify and describe all medical, epidemiological, dental or scientific facts and evidence (including the title and date of any journal article or other publication) upon which Bragdon relies for any contention that his Infectious Disease Policy with respect to patients with HIV or AIDS is necessary because HIV can be transmitted in the Bragdon Office through dental instruments, including but not limited to the high and low speed dental handpieces.

OBJECTION: Defendant objects tot his interrogatory on the basis that it is overly broad and unduly burdensome.

ANSWER: Without waiving this objection, please see answer to interrogatory number 8.

12. State all medical scientific facts and evidence upon which Bragdon relies for this opinion, judgment or belief, if any, that the types of gloves, masks and protective eyewear identified in response to Interrogatory Number 3 are in any way inadequate.

ANSWER. Please see answer to interrogatory number 8.

13. Identify by date, journal and title any publication, research, or study, including but not limited to the Morbidity and Mortality Weekly Report published by CDC, or any publication of the American Dental Association, which Bragdon maintains documents or proves transmission of HIV from patient to dental worker or from patient to patient in a

medical or dental setting.

ANSWER: Please see answer to interrogatory number 8.

14. Specify and describe in detail each and every way in which Bragdon maintains that any of the universal precautions, recommendations, or mandates of the CDC, OSHA or the American Dental Association to prevent the transmission of HIV in dentistry are ineffective or inadequate.

ANSWER: My attorneys will provide expert positions on this issue in accordance with the Federal Rules of Civil Procedure.

15. Identify and describe in detail each and every way in which Bragdon maintains that treating a patient with HIV or AIDS in a hospital surgical operatory reduces, minimizes, or eliminates the risk of transmission of HIV from a patient to a dentist or dental worker in comparison to providing the same dental services to an HIV-positive patient in the Bragdon office.

ANSWER: My attorneys will provide an expert position on this issue. It is well established that a hospital operatory provides a state of the art environment for invasive procedures and safety to staff and patients. For example, air filtration, ultraviolet lights, complete scrub down of floors and equipment between patients and the use of respirators (rather than masks) occurs in a hospital setting.

16. Identify and describe in detail each and every way in which Bragdon maintains that treating a patient with HIV or AIDS in a hospital surgical operatory reduces, minimizes, or eliminates the risk of transmission of HIV from a patient to another patient in comparison to providing the same dental services to an HIV-positive patient in the Bragdon Office.

ANSWER: See answer to interrogatory 15. In addition, in a hospital setting it is likely to have available space for additional assistants to make transfers to the chair side assistant.

17. Specify and describe in detail all reasons not identified in Interrogatory Numbers 15 and 16 that Bragdon believes a hospital or surgical operatory provides better infection control protection than Bragdon can provide in the Bragdon office.

ANSWER: See answers to interrogatories 15 and 16.

18. State the name, job title, job responsibilities, home address and dates of employment of each person employed by the Bragdon Dental Practice from 1980 to present and identify which of those employees was present and working in the Bragdon Office on September 16, 1994.

ANSWER: Randon Bragdon
129 Hudson Road
Bangor, Maine 04401
General Dentist-Sole Proprietor
1978 to present

Judith Bragdon
129 Hudson Road
Bangor, Maine 04401
Office Manager
1978 to present

Cheryl Bell
RFD #1, Box 24
Levant, Maine 04456
Receptionist
1987 to present

Kristin Long
57 Veazie Street
Old Town, Maine 04468
Dental Hygienist
1989 to present

Kimberly Hayward
RR 1, Box 1238
Dixmont, ME 04932
Chair side assistant

1992 to present

Bethany Bragdon
129 Hudson Road
Bangor, Maine 04401
Part-time receptionist
January 1991 - May 1991

Tracey Wren Frost
RR#2, Box 347
Carmel, ME 04419
Dental Assistant
April 1987 - September 1992

Tina Brown
RR#2, Box 200
Dover-Foxcroft, ME 04426
Temporary Dental Assistant
September 1994

Jean LaRochelle
P. O. Box 164
Carmel, Maine 04419
Temporary Dental Assistant
October 1994 - November 1994

Evelyn Hobbs
18 C Street
Bangor, Maine 04401
Part-time Clerical
October 1987 - January 1989

Kelly Emery Estes
P. O. Box 331
Hartland, ME 04943
Hygienist
August 1985 - April 1989

Kimberly Mitchell
1794 Broadway
Bangor, Maine 04401
Part-time Hygienist

February 1984 - April 1986
December 1987 - January 1988

Angela Glidden
707 Hammond Street
Bangor, Maine 04401
Hygienist
December 1987 - January 1988

Linda McBrine
46 Mt. Desert Drive
Bangor, Maine 04401
Part-time Dental Assistant
August 1984 - December 1984
February 1985 - May 1985
October 1986 - August 1988

Laura Young
35 Harlow Street
Brewer, Maine 04412
Receptionist
August 1984 - August 1987

Frances Turcotte
262 Parkview Avenue
Bangor, Maine 04401
Part-time Dental Assistant
March 1987 - April 1987

Tammy Allen Brown
RR #1, Box 105C
East Corinth, Maine 04488
Dental Assistant
September 1984 - February 1987

Denise Cousins
35 Holyoke Street
Monson, Maine 04464
Temporary Dental Assistant
June 1986

Mary Ann Hewes Bjork

P.O. Box 101
Monson, Maine 04464
Temporary Hygienist
October 1985 - December 1985
May 1986 - June 1986

Roxanne Horne
13 J.R. Drive
Lincoln, Maine 04457
Part-time Hygienist
September 1983 - June 1985

Linda Corthell
P. O. Box 141
Pembroke, ME 04666
Temporary Receptionist
January 1985

Michelle Warren
RR#1, Box 1710
Bangor, ME 04401
Part-time Clerical
February 1985 - September 1985

Debra Howell
249 15th Street
Bangor, Maine 04401
Temporary Hygienist
October 1985 - December 1985

Noreen Hashey
RR#1, Box 535
Kenduskeag, ME 04450
Temporary Receptionist
February 1985

19. Describe and state in detail the dates, location, parties to and substance of all communications (written or verbal) between Abbott and any employee of the Bragdon Dental Practice, including but not limited to communications on September 16, 1994.

ANSWER: At some date previous to September 16, 1994 Sidney Abbott made an appointment for the apparent purpose of determining the cost of a filling. Cheryl Bell probably received the call and it was probably made in July or August of 1994. All that is known about the call is that the notation was made in the appointment book the patient only wanted to know the cost of a filling.

In reviewing the medical and dental history Sidney Abbott filled out, I noted that she had checked she was HIV+ and was allergic to Bactrim. I asked her if she had any medical problems. Ms. Abbott said that she had been HIV+ for eight years with no symptoms or problems. I asked her what I could do for her and she said she was wondering how much it would cost to have me do a filling on the lower left. She indicated that she had been advised of the cavity at another office. I examined the carious lesion and did a general examination of her mouth and oral cavity. She verified that a small carious cervical lesion on the buccal of #19 was the cavity she was interested in. I informed her that my fee would be either $35.00 or $45.00 and I would be happy to treat her in a hospital setting. She would be responsible for the hospital fees. I explained my infectious disease policy to her and that I did not feel that the dental operatory was a proper setting for treating patients with serious infectious diseases. She had no questions about my infectious disease policy or what would be involved. She did not indicate that she had any objections. She said that she would think about it and let me know if she wanted it done. On the way out she asked if there was any fee. I told her no. I do not regularly charge a fee in the few instances where the request is simply to inquire as to the cost of a service.

20. Describe in detail all communications (verbal or written) between Abbott and Bragdon, including but not limited to communications on September 16, 1994, and state the name, job title and home address of any person who was present during or witnessed any such communications.

ANSWER: See answer to interrogatory 19. The only other brief communication would have been Cheryl Bell asking the patient to fill out the medical and dental history and general

information form. Judith Bragdon was present during communication with plaintiff.

21. Describe in detail the nature, extent, and findings or results of any dental examination, treatment, or services provided by Bragdon to Abbott, including but not limited to September 16, 1994, including an itemization of all diagnostic procedures and dental treatment performed on Abbott.

ANSWER: There was no treatment except a general examination.

22. Describe in detail the circumstances and conditions upon which Bragdon would have provided dental treatment to Abbott in September, 1994, including filling her cavity, specifying the precise hospital or institution where the treatment would take place, whether Ms. Abbott would have been required to pay for the cost of the hospital facility or surgical operatory, who would pay for any additional staff, special instruments or lab tests which Bragdon claimed were necessary, and any and all plans which Bragdon had in place as of September 16, 1994 to implement a plan of treatment for Ms. Abbott.

ANSWER: I would have expected to treat her at Eastern Maine Medical Center but have since learned that the hospital has not kept up its dental equipment. Ms. Abbott would have been responsible for the hospital charges, any fees her physician might have charged for my consulting with him and recommended laboratory tests. She would not have been charged for the second assistant that I feel is necessary in treating an infectious patient in a dental environment.

23. Identify name, current home and business addresses, and telephone number each witness whom Bragdon intends to call at the trial of this action and state the subject matter and substance of each such witnesses' testimony.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which was prepared in anticipation of litigation or in preparation for trial, and if, therefore,

protected by the work product doctrine.

ANSWER: Trial witnesses will be identified prior to trial in accordance with court orders and the Federal Rules of Civil Procedure.

24. Identify the social groups or populations which Bragdon believes or understands to be at higher risk for HIV or AIDS in Maine and the United States.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which is not relevant to this litigation, nor reasonably calculated to lead to the discovery of admissible evidence.

25. Identify by name and address each political, medical, dental, religious, community or other organization, association or political party to which Bragdon has belonged or been affiliated with in any way from 1980 to present, specifying in your answer the nature and extent of Bragdon's role or participation for each entity.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which is not relevant to this litigation, nor reasonably calculated to lead to the discovery of admissible evidence.

ANSWER: With regard to medical and dental entities, defendant responds as follows: I do not and have not belonged to any medical associations. With regard to dental associations I am and in the past belonged to the American, Maine and Penobscot Valley Dental Associations. I also have been associated with Academy of General Dentistry, the American Orthodontic Society, the International Association of Orthodontists, International Dental Health Foundation, and International Association of Physicians for AIDs Care.

26. With respect to each such entity listed in Interrogatory No. 25, describe and state any positions, opinions or statements made by the organization or by any member, employee, director, or officer from 1980 to present regarding AIDS or HIV, homosexuality or bisexuality,

including in your answer the title, date, and name of journal, in which any such position, statements or opinions were made.

OBJECTION: Defendant objects to this interrogatory to the extent it seeks information which is not relevant to this litigation, nor reasonably calculated to lead to the discovery of admissible evidence.

27. Identify and describe in detail any occasion from 1978 to present in which Bragdon has provided dental treatment or services to any person with an infectious disease, including but not limited to HIV or AIDS, tuberculosis (active or inactive), strep throat, hepatitis A,B,C and non A-B, syphilis or any other sexually transmitted diseases, measles, mumps, or chicken pox stating the date, the location where the treatment was provided, the precise nature of the dental services or treatment performed, and any infection control procedures utilized which Bragdon did not at the time such services were rendered regularly utilize for patients without that infectious disease.

ANSWER: I have not knowingly treated a patient with serious infectious disease. Occasionally, I have learned after the fact that I had treated a patient with an infectious disease.

28. Identify any person, patient or prospective patient other than Sidney Abbott who has indicated to Bragdon that he or she is HIV-positive or has AIDS and with respect to each such person, state whether Bradgon provided any services to such person, the location and nature of the treatment, any referral made to another provider, and the reason if Bragdon did not provide any treatment.

ANSWER: Plaintiff's counsel is aware of a patient known as "John Doe" who's situation may be responsive to this interrogatory. I do not recall any other such circumstances.

29. Describe all training and education provided by Bragdon to his staff and employees regarding infection control, universal precautions, AIDS, or HIV from 1990 to present.

ANSWER: See answer to interrogatory 3. The information identified in interrogatory 3 includes training and education provided.

30. Identify all dental periodicals which Bragdon subscribed to and regularly read from 1985 to present.

OBJECTION: Defendant objects to this interrogatory on the basis that attempting to respond would be unduly onerous. Without waiving such objection, I have subscribed to and regularly read the following:

Journal of American Dental Association
ADA News
Journal of American Academy of General Dentistry
AGD Impact
MDA Journal

/s/ John W. McCarthy, Esq.
/s/ Randon Bragdon, DMD
/s/ Jurat

SANFORD F. KUVIN, M.D. DEPOSITION EXCERPTS OF VOL. 1, JULY 20, 1995 DEPOSITION

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Q: Is it your impression that Dr. Christianson believes that HIV-positive patients can never be treated for routine dental care in the dental office but should always be referred to?

A: No. I want to be quite careful and candid. I can't speak for what Dr. Christianson thinks. But I do believe that Dr. Christianson feels that HIV patients have not been afforded the type of good care they need, and that her general thesis, without speaking for her, is very much in accord, perhaps not in total accord with Dr. Bragdon. But certainly the conceptual policies are similar.

Q: So it's your understanding that Dr. Christianson thinks that sometimes HIV-positive patients should be referred out of the dental

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office for specialized care?

A: Yes.

Q: But not all the time?

A: I don't know that.

Q: Are you aware of any public health authority that says HIV-positive patients should always be referred out of the dental office for routine dental care?

A: I thought I tried to answer that question earlier on.

Q: Can you answer it now, please.

A: It's my opinion that there are several public health authorities that suggest that all, not all HIV - strike that - that HIV patients should be referred for specialized care under given circumstances.

Q: Are there any that say under all circumstances HIV patients should be referred out of the dental office

A: I know of no -

Q: Excuse me - for routine dental care?

A: I know of no organization that says that all HIV patients should be referred outside the dental office for

routine dental care.

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Q: Do you personally believe that all HIV-positive patients should be referred out of the dental office for routine dental care?
A: I don't think I'm really - I'm not a dentist. And in all candor am not familiar with the vagaries of dentistry as to what goes on in a dental operatory, whether it be aerosol spray or contaminated water lines or other patients in the operatory or people who have cough reflexes who are more sensitive than other cough reflexes and what saliva is being spewed about. I just am not familiar with that.
Q: You referred earlier to some specially designed treatment centers that you had heard about in New York for HIV-positive patients; is that right?
A: I did mention that.
Q: And that was accurate testimony?
A: Would you kindly explain your question?
Q: You're aware of specially designed treatment centers for HIV-positive patients in New York: is that right?
A: I said yes.
Q: And they handle routine dental treatment:

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is that right?
A: To the best of my knowledge.
Q: What's the basis of your knowledge in that regard?
A: Published reports. I've made no site visits, and I don't pretend expertise in these centers at all.
Q: And the published reports?
A: I read Dr. Bragdon's deposition where he referred to several of these centers. In conversations I've had with Dr. Michael Glick - that's not a published report. I'll retract the word "published" - but he told me about centers in the course of just general conversations.
Q: Is it your understanding that special infection control procedures other than universal precautions are followed at these specially-designed treatment centers

when HIV-positive patients are being provided routine dental care?
A: It's my understanding that these centers cater to a clientele where it is understood that all patients are potentially HIV infected, and therefore the level of care is geared to that concept. It's my understanding that the universal

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precautions employed are similar to those employed elsewhere. But it's the intensity and the knowledge that most if not all of these patients in fact are HIV infected, and therefore the intensity of care is so relegated towards that.
Now, having said that, I don't know whether certain centers, whether St. Claire's in New York or the center in Chicago, but I do believe some of them, if not all of them, but some of them perhaps use other engineering methods that are associated with the risk of other germs associated with HIV, in particular TB, where facilities are engineered that could not be accommodated in an accommodation such as Dr. Bragdon's office with reverse air flow, ultraviolet light, HEPA filters, major alterations in the engineering, for lack of a better word, for ancillary care to prevent aerosol transmission of other germs.
Q: Is your opinion in this case based on the understanding that there are specially designed treatment centers where infection control procedures beyond universal precautions are followed when providing routine dental care to HIV-positive patients?

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A: As I said to you before, I don't have specific knowledge of that.
Q: So you're not sure about that?
A: I'm not sure about that.
Q: And in fact some of your information has come from reading Dr. Bragdon's deposition transcript, right?
A: And conversations with other dentists.

Q: On the phone or in person?
A: Over the phone or in person.
Q: And that's the extent of your knowledge of these specially-designed treatment centers?
A: Yes, it s.
Q: Besides Dr. Glick, can you recall any other dentist or person that you've spoken to about specially-designed treatment centers for HIV-positive patients?
A: I've had some conversations with dentists across the nation about the issue of infection control. I'll be happy to give you some of their names that I can remember, but I can't recollect whether it was specifically geared toward the specialized centers.
Q: Please give me the names of people who

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you believe you discussed the specially-designed treatment centers for HIV-positive patients with?
A: I can't recollect specifically other than when I mentioned Dr. Glick to you. But other than - I can't recollect, as I just said to you, whether I discussed the specially-designed treatment centers with these other dentists, although the discussion was involved with infection control I can tell you who I discussed infection control with, but I can't tell whether or not special treatment centers were incorporated in that discussion ...

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... tions by his staff. And yet, this cluster of cases of HIV occurred in Florida. We also know conversely that health care workers have been infected, because blood is a two-way street. And it's not surprising, therefore, that health care workers have been infected from patients. And the CDC lists health care workers that have been infected with HIV.
The official numbers, as you know, are about 42; but there are an additional 91 which are also on the list, six of which are dentists.

Having said that, we know that gloves rip, tear, leak. They're porous. They have many defects to them. And there is not much evidence to show in the literature that a reduction in disease has occurred of great significance since the introduction of universal precautions with barrier techniques.
However, I said before, I'm a great advocate of it, because medical logic suggests that using barriers will prevent disease transmission. In trying to prevent the transmission of HIV in the dental operatory, the use of gloves, the washing of hands in between patients, the double gloving where possible, are all methods of universal precautions to reduce the risk, although the risk is still there. It's significant. It's real. It's a low risk. But it's certainly absolutely real.
And in trying to reduce the risk, the dentists should wear these gloves. And you asked how can this protect. But unfortunately the dentist, as we know, will stick himself or herself

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no matter how hard he or she will try to not stick him or herself. And as you well know, the literature is replete with studies to show that no matter what care responsible invasive health care workers take, they will and are guaranteed to stick themselves, because , after all, they're making human errors.
With regard to other methods of prevention, utilizing universal precautions; the sterilization of instruments; the sterilization of hand pieces, even though there's no evidence that the hand piece has ever transmitted HIV, have been put into use. And in fact many recommendations of the CDC, which in part sets our standard of care, many of their recommendations have been made based on medical logic and not necessarily on hard science.
There's nothing in hard science to show that sterilizing hand pieces prevents the transmission, or indeed there's been no transmission that's been documented of HIV through an unsterile hand piece. But yet the Centers for Disease Control says the standard of care should be

to sterilize all hand pieces. No science behind it

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but medical logic.
And this whole discussion, and please accept this, is based on medical logic. Nothing more, nothing less.
And the problem with dealing with something of this terribly important nature, namely the health of the uninfected, the rights of the uninfected, the right to know, the duty to warn, are all based on medical logic.
Now, to continue with my answer on your question about protecting, using universal precautions, the use of masks is certainly in order. Does it prevent the spread of HIV from the patient to the health care worker? There is no evidence that suggests that.
However, the CDC in its wisdom says wear a mask.
Again, medical logic. Why? Because there's no evidence to suggest that aerosol spray can transmit HIV. But do they know for certain? No.
In fact, if one looks at the very recent issue of the Morbidity and Mortality Weekly Report of just a week and a half ago, you'll find an update on viral hemorrhagic fever. Ebola virus. And it's updated for the United States. And what it says is that there is no evidence of aerosol

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transmission of Ebola fever, however, don't assume that to be totally correct, because we know that monkeys can do it by aerosol.
We know that there's no evidence to suggest that it can occur in man, but be aware and take precautions against it. So it merely is a paradigm of what we don't know and what we're searching for. And I hope and pray that all of us are searching for the better health of the American public.

Q: When you refer to science, you're referring to cases that have been documented; is that right?

A: That's correct.

Q: Do you believe the CDC is a reliable authority on the

transmission of HIV?

A: Certainly I believe the CDC is a reliable authority on the transmission of HIV.

Q: You mentioned that giving birth is a mode of transmission of HIV; is that right?

A: That's correct. Please let me say that it would have to be from an HIV infected mother to a newborn.

Q: So if you're female HIV positive there's

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a substantial risk that your child will be HIV positive?

A: There is indeed.

Q: And you mentioned the exchange of blood and bodily fluids is another mode of HIV transmission?

A: That is correct.

Q: Which bodily fluids are you referring to?

A: Vaginal secretions; semen; body fluids of the abdominal cavity where a surgeon has his or her hands in the cavity and there's an exchange of fluids; the oral cavity, of course, if there are cuts, abrasions; the mucocutaneous entrance. That's not an exchange, but the mucocutaneous surfaces such as the eye, rectum, can receive the virus.
Saliva contains the virus, of course, but by most authorities not in quantitative amounts that are readily transmitted, unless mixed with blood. And as you may know, there have been cases of transmission through sexual acts of cunnilingus which have been documented by the CDC. So whether that's pure saliva or saliva mixed with other things has yet to be determined. But there are,

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for the record, examples of cunnilingus where HIV has been transmitted.

Q: Is your opinion in this case based on the assumption that saliva is a mode of transmission from an HIV-positive person to another person of HIV?

A: I said there's been no evidence to suggest on the face of it that saliva unattended, namely, not mixed with blood,

has been a method of transmission. I would have to add parenthetically, however, that the virus does exist in saliva, but I would also say not in quantitative amounts that have been shown to be transmissible. And, just for the record, there are some anti-HIV constituents of saliva which may negate against the virus itself.

Q: And it's your understanding that sweat is not a bodily fluid that transmits HIV?

A: That's correct. However, sweat is a bodily fluid that can transmit hepatitis B.

Q: So in the dental office the primary body fluids by which HIV could be transmitted would be blood, is that right?

A: Yes. And as I said, and I've already disclaimed saliva in its pure form, but saliva

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mixed with blood certainly.

Q: But it would be the blood that does it?

A: It would be the blood that does it, yes.

Q: In a situation where the blood has some saliva mixed with it, in your opinion would that blood be less likely to transmit HIV because of the anti-HIV qualities in the saliva?

A: No. I don't think that the talking point, as it were, of the anti-HIV quality of saliva is really germane to the over-riding infectivity of blood, the transporter of significant amounts of virions. You could argue how much saliva, how much blood. If it's visibly bloody, it's infections.

Q: Does the transfer of blood from an HIV-positive person to another person who is not HIV positive always transmit HIV to the recipient?

A: No.

Q: In fact most of the times it would not transmit HIV correct?

A: Most of the time it would not transmit HIV.

Q: What are the factors in your opinion that would affect the likelihood of whether the blood

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would transmit HIV?

A: Basically the two factors would be the quantity of virus in the blood and the resistance of the host, of the person that is receiving the HIV, the medical condition, as it were, of the person receiving the inoculum of blood.

Q: When you refer to the quantity of virus, is it fair to say that the more volume of blood you have, the more quantity of virus you're going to have?

A: As a general proposition that would be correct, but of course you could have a small quantity of blood with a very large quantity of virus of a large quantity of blood with a small quantity of virus. I think the descriptive would be viral load.

Q: Assuming you have an HIV-positive patient, is it fair to assume that the larger the amount of blood the more viral load you're going to have?

A: No, that's not a correct assumption. In different stages of HIV, the viral load is different. Therefore a small quantity of blood when there's a high viral load may have more of a

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quantity of infectious agent that a large quantity of blood when the load is lower.

Q: Maybe you didn't understand my question. You have an HIV-positive patient in front of you. If you take a large bit of blood and you put it here, and you take a small bit of blood and put it here, you can assume that you're going to have more virus in the larger sample of blood, correct?

A: That's absolutely correct.

Q: But you're also saying that concentration of virus varies temporally in an HIV patient and also between HIV patients?

A: That's correct.

Q: Are there any factors that correlate with the concentration of viral load?

A: There have been several propositions put forward, none of which are necessarily constant. Early on, in the

early stage of the disease, the viral load is supposed to be higher. If there are cofactors that the patient with HIV has like cofactors meaning other diseases or other health-related matters, that may or may not impact on HIV. These cofactors may reduce the resistance of the HIV patient to some immunological status where

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the concentration of the virus may be elevated.
The concomitant use of antiviral drugs, of course, may alter the viral load. The general health and well-being of the patient, if they're malnourished, if they're diseased from other causes aside from cofactors, may alter the viral load. And of course there's the stage of the disease that the patient is in. If they're in a stage of - their position may change radically where the viral load, particularly if they're near death, their viral load may increase substantially.

Q: Do you agree with the evidence indicating that the viral load is highest at the very beginning of the onset of HIV?

A: I think that's correct.

Q: That would be during the first one to six months?

A Given a broad range of description, because this disease, although it has a bell-shaped curve to it, it has all sorts of extremes.

Q: But is that one-to-six-month range a fair description of the period in which the viral load would be highest?

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A: I would say that would be a fair description.

Q: And the other time at which the viral load would be highest is when a person begins to experience symptoms and develops AIDS, is that right?

A: Yes. You used the word AIDS. AIDS is a descriptive term in my opinion. It's one disease. HIV/AIDS is one disease.

Q: As the HIV becomes more and more symptomatic, the viral load would tend to increase?

A: Yes.

Q: You also referred, you also testified that the medical condition of the recipient would affect the transmission of HIV; is that right?

A: Yes.

Q: I take it the better the medical condition of the recipient the less likely it is that the HIV would be transmitted to the recipient?

A: In general. However, we're dealing with a uniformly lethal disease. With aberrational exceptions, this disease has no survivors; therefore, the potential for transmission is so overriding and is so significant and so devastating

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that whether we're dealing in gradations of highly infections - or let me rephrase that by saying in my opinion HIV is a disease of low infectivity. Having said that, within a premises of low infectivity, there are all gradations of the high end of that low infectivity or the low end. But be that as it may, it's infectious. It's infectious for life. The risk is devastating, and it's real.

Q: You indicated that there are aberrational exceptions to HIV being fatal; is that right?

A: When I use the word "aberrational," I'm saying it's so rare as to be recorded as rare and needs further investigation, because maybe those small number of cases will help us in finding out why these people don't get sick and die and whatever. I only use it in that general context of discovery. Again, we're in a period of trying to unravel this, for lack of a better word, this plague, which is the worst disease to come on the fact of this earth.

Q: When you say "rare." You mean less than 1 percent?

A: Yes.

Q: But I take it your adopting …

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A: That would be true in the best of all worlds. But, as

you may know, more likely than not, the HIV-infected patient as opposed to the general population, as opposed to the non-immunosuppressed population, often will have no symptoms. And the converse, just from a medical point of view, are signs. Symptoms means cough, pain, what have you. A sign is-where there's a demonstrable change in the patient's physical condition.

So the problem with HIV in general is that it is a disease which in essence hides other diseases. And, therefore, the health care worker is left with the rather onerous decision of what to do about such a patient, and particularly where little is known about the medical history because in the State of Maine HIV is not a reportable disease.

Q: Of course if the patient voluntarily discloses that to you, that's not a problem?

A: That's not a problem if the patient voluntarily disclosed it.

Q: And in this case the patient voluntarily disclosed her HIV status to the dentist, right?

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A: Yes.

Q: Is it your opinion that dentists should assume that all HIV-positive patients, regardless of the status of their disease, have TB?

A: It's my position that a dentist should consider that possibility very seriously because of the epidemic proportions of TB that are now engulfing this country.

This is not something to be scoffed about or something to be put into anything else but the most serious of terms.

In Bath, Maine one person transmitted TB to 419 people in one small town in Maine. In several clusters of cases in major metropolitan areas, there has been an epidemic of, not a reactivation of latent TB, but the spread of TB from person to person from HIV individuals.

And everybody, when I say "everybody," people of prominent authority from Dr. Dixie Snider, the head of

TB control division at the CDC, to Dr. Anthony Faucchi to virtually every prominent person in the field of infectious disease control has articulated this warning on a national basis and to health care workers in particular.

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And let me add, that several health care workers have died from TB in metropolitan areas of this country in recent years. So I'm not saying anything other than what is recognized in the scientific world, that we are in the throes of a tuberculosis epidemic, which is in part being driven by HIV.

Q: Are you finished?

A: Yes.

Q: Is your opinion in this case based on the assumption that there is a risk of transmission of HIV involving the hand pieces used in the dental office?

A: I don't know, in all candor, whether that is true or not. There have been experts, Dr. Lewis is one national expert in dentistry who has suggested that. There have been others. Again, I will say to you that the CDC has made it the standard of care to sterilize all hand pieces by heat as opposed to cold sterilization. It is also a reasonable conclusion of medical logic to assume that they are concerned about the transmission, even though no transmission has been proven.

Q: Are the CDC's universal precautions

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designed solely to deal with the transmission of HIV?

A: No. They're designed to deal with the transmission of HIV, hepatitis B and other blood-borne diseases. And let me just parenthetically add that whenever the CDC has issued a recommendation, it's been for HIV, hepatitis B, and other blood-borne diseases. And, therefore, Dr. Bragdon is not just talking about HIV in his infectious disease policy. He is talking about an overview of serious infections, plural. HIV is prominent amongst them, but it's not the only one.

Q: Is your opinion in this case based in part on your concern that HIV can be transmitted through the hand pieces in the dental office?

A: If the CDC has decided in its wisdom that the hand piece should be heat sterilized, then in fact if the practitioner is following CDC guidelines, which is the standard of care, then there would be no risk of transmission of HIV in the dental office through the hand piece.

MR. McCARTHY: Excuse me before you ask a question.

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(The witness and attorney confer.)

Q: You testified earlier that a risk of HIV transmission remained in the dental office through cuts or abrasions despite the use of universal precautions; is that right?

A: Yes.

Q: Could you explain how such a transmission would occur from patient to dental workers?

A: Certainly. If a dentist, Dr. Bragdon is operating on Ms. Abbott and the field is bloody and Dr. Bragdon sticks himself and bleeds, which allows an ingress of blood into Dr. Bragdon and his hand is in the mouth cavity of Ms. Abbott, then Dr. Bragdon runs a risk of contracting AIDS from Ms. Abbott.

Similarly, if Dr. Bragdon cuts himself and bleeds into Ms. Abbott's mouth while she in turn is undergoing a procedure which required or results in bleeding in her mouth, then there will present a potential position of the co-mingling of blood and oral fluids, which will be co-mingled between Ms. Abbott and Dr. Bragdon. I suppose one could hypothesize to the remote that Ms. Abbott could bite Dr. Bragdon.

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But putting that aside as a remote possibility, the main event is the co-mingling of blood in a bloody field where Dr. Bragdon has either stuck himself or cut himself, of if Dr. Bragdon had some lesions on his

hand which were eczematous or some for of dermatitis and his gloves were less than perfect, they were holey, they were unholey, they were ripped, they were torn, they slipped, whatever. In other words, if Dr. Bragdon allowed an entry of blood into his hand through lesions on it, that would be another method.

And then, of course, if Ms. Abbott were in a situation where her cough reflex was stimulated, as all of ours has been in a dental office, and she decided inadvertently to cough and blood went into Dr. Bragdon's eye, Dr. Bragdon would then be subjected through a less common but nevertheless real method of transmission of a blood-borne virus.

So blood, blood is a two-way street. It goes from patient to health care worker. It goes from health care worker to patient. There's nothing unusual about that. It's gone on ever since medicine was invented 5,000 years ago in

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Egypt. And the fact that we're dealing with a uniformly lethal blood-borne virus today is very significant.

It's a tragic disease, as we all agree. And although the health care aspect is not the main event, it is certainly ...

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Q: Any other authorities that your relying on for the proposition that persons with HIV who are otherwise asymptomatic are more likely to get TB than the average person?

A: Well, in the June 16 issue of the New England Journal of Medicine of 1994 - the authors' names unfortunately escape me. There are two articles plus an editorial which clearly articulate not only the authors' opinions, Dr. Snider's opinions, but the references, at least in the dozens which also articulate or rearticulate this opinion about HIV-infected patients having this extraordinary

propensity for getting TB because of their HIV status.

Q: Based on your understanding of these studies that your citing, is the increased risk of TB for HIV-positive patients the same regardless of how symptomatic they are?

A: That's something that is open to medical debate, not debate, but inquiry at the moment. Certainly the more advanced a person's illness is with HIV and the more they are immune compromised, they would therefore logically have a greater propensity toward getting TB. But there is also no

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doubt about it that HIV patients who are apparently feeling well, acting well and not in any advanced state of disease - although by the definition of having HIV means that they're seriously ill. Just having the virus means that you're seriously ill. They too have a much greater risk of getting the disease. But what's equally cogent is that they have a great risk of transmitting the disease, not only getting it but transmitting it to others.

Q: You're referring to TB?

A: Yes.

Q: Is it your understanding that these studies indicate that even if an HIV-positive person has a regular CD-4 count they're more likely to get TB than another person with the same CD-4 count who is not HIV positive?

A: That's correct. And furthermore, the -

Q: Is this responsive to my last question?

A: Yes, just to complete the answer to it. And, furthermore the amount of multiple drug resistant TB amongst this very class of patients, namely the HIV-infected patients, is in much greater proportion than the general population. In other words, the incidence of multiple drug

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resistant TB, which as you know is treatable to the extent of about 20 percent. Under current technology, about 70 to 80 percent of these patients die. The

frequency of multiple drug resistant TB is inordinately large in HIV-infected patients.

Q: Do you believe that HIV-positive patients are entitled to receive routine dental care?

A: Unequivocally.

Q: And you think that can be safely done at least in some settings?

A: Absolutely.

Q: In Paragraph 2 of your report you indicate that treatment of patients suffering from the HIV virus is not a civil rights issue?

A: I believe that.

Q: You think it's improper for the government of the United States to enact civil rights legislation to protect the rights of persons with HIV?

A: No.

Q: Do you think laws doing that are unconstitutional?

A: No.

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Q: You think those laws should be repealed?

A: No.

Q: In Paragraph 5 of your report you state that, "There's ample evidence that HIV is transmissible from patients to health care workers and from health care workers to patients in the invasive health care setting." What evidence are you referring to?

A: I think you left off the last sentence of that paragraph.

Q: I did. I was referring to the first sentence of the paragraph.

A: Okay. But just for completeness, the paragraph was not read in its entirety.

Q: The word "ample evidence" only appears in the first sentence that you choice [sic] to write in your report, correct?

A: Yes.

Q: And I'm focusing on the words "ample evidence" and asking you to explain what the ample evidence is for the rest of that sentence that you wrote.

A: I just want to be quite clear that you haven't read the entire paragraph.

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Q: Well, for the record, I haven't read the entire report.
A: We're talking about a paragraph that has one further sentence to it.
Q: You're absolutely right.
A: Thank you. The ample evidence for blood-borne viruses and other infectious agents such as HIV are transmissible from patients to health care workers and from health care workers to patients is as follows: We have a paradigm of a blood-borne virus of hepatitis B that has been shown repeatedly to be transmitted to health care workers from patients in the thousands. And, in fact, approximately 200 to 400 health care workers die each year, have died in the past each year as a result of hepatitis B transmission from patients to health care workers.
The recent improvement - as you know, I'm chairman of the hepatitis B action group. The recent improvement in the technology of hepatitis B is that there is now for the first time - it's been around for a number of years - the safest, most effective vaccine ever made to prevent hepatitis B. Unfortunately, the utilization of

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that vaccine has not been what it should be.
It's getting better. However, it doesn't take away from the fact that still even in today's world, people are dying needlessly from the transmission of hepatitis B from patients to health care workers. And last year there was reduction, but there were still a significant number of health workers who were getting the blood-borne virus of hepatitis B from their patients and dying from it. Countless thousands, hundreds of thousands have gotten it over the years and have not died, some of which have had no illness or minimal illness, some of which had long-lasting effects of cirrhosis. And others, of course, have gotten primary carcinoma of the liver.
Conversely, within that question that you asked about

ample evidence that blood-borne viruses of infectious agents being transmissible between both the patient and the health care workers and the health care workers and the patient, the converse has occurred where over 300 to 400 patients have gotten hepatitis B from their health care workers who were carriers of hepatitis B.
Now, the field of dentistry has been

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investigated with regard to that, of course. And it was found in the earlier days, a few years ago - and we have to refresh our memory occasionally, I think, that we're dealing with a new disease. HIV only came into this country in 1981. So in terms of modern technology, we've learned that hepatitis B - and, by the way, the chap who won the Nobel prize for hepatitis B discovered it in the '70s.
We're dealing with recent events in terms of medicine. These are not old time diseases. These are brand new emerging diseases of which we are constantly discovering new knowledge virtually every day. We learned that the transmissibility of hepatitis B is highly infectious, 100 times more infectious than HIV, easily spread and much more easily spread than HIV. And knowing that and with all the universal precautions in place that were recommended as the standard of care, still hepatitis B was spread to approximately 300 patients.
It was found that some of these patients were under the care of dentists who were highly infectious with hepatitis B, virtually all

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of them carrying what is called the E antigen which is the most infectious form of the virus. And some of them were removed from practice. Some of them gave up practice voluntarily. And since that time, the dentists have not been recorded, documented at least, as transmitting hepatitis B to their patients.
One would say, therefore, universal precautions

worked. Unfortunately, that's not the case. And in recent times within the last several years there have been other clusters, a total of 33 clusters of transmissibility of hepatitis B to patients when all universal precautions were taken, single gloving, double gloving, all under the scrutiny of the operating room where it wasn't a private dentist's operatory. It was a big time hospital operating room with the scrutiny of scrub nurses, other doctors, whatever, watching the technique, no break in surgical technique. And yet this cluster of hepatitis B was indeed spread. So that is ample evidence in my opinion of the spread of an - that is ample evidence of the spread of a blood-borne disease,

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both between the patient and the health care worker and the health care worker and the patient, reflecting the common sense, logical observation that blood is a two-way street. The method of spread still remains to be determined. Then we move into other blood-borne diseases, HIV.

Q: Let me just clarify that my question was about the ample evidence that supports part of your opinion concerning HIV being transmittable from patients to health care workers and from health care workers to patients in the invasive health care setting.

A: I'll be happy to address that, but I don't think that was the questions originally. You read the blood-borne viruses.

Q: Just to clarify, I'm asking you for all the ample evidence that supports your view that HIV is transmissible from patients to health care workers and health care workers to patients in the invasive health care setting.

A: Fine. If I restrict my answer to your singular question about HIV alone and not other blood-borne diseases of which there are many -

MR. McCARTHY: Just a second. Just

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in case you are so restricting him, I want to be sure that his position is understood, which is the activity in these other fields, for example, hepatitis B, by analogy is relevant to the question of whether there's ample evidence. If you don't want him to give you that information, just, again, that's what you're saying, then he won't.

MR. WEBBERT: I think you're coaching the witness. I think he's fully capable of answering questions. What I asked him was quite clear. What is the ample evidence that supports his view with respect to HIV. If he wants to bring in anything, whatever he wants to say, it's up to him, and that's all I want to hear.

MR. McCARTHY: I'm quite sensitive about lawyers coaching witness. I'm not doing that. It seems like you must not have been paying attention, because that's what he just said about HIV and hepatitis B. But you ask the questions and get the answer. I just wanted to be sure if you were limiting him that later on you won't say, You didn't say that when I asked you before at deposition.

MR. WEBBERT: I think my question is

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quite clear that I'm asking about the transmission of HIV. I am in no way limiting his ability to refer to any other disease or anything in the world he'd like to cite as ample evidence.

Q: And if you want to say that what you just said about HBV is part of your answer, that's fine. Whatever you want to say, it's up to you.

A: By definition what I just said about hepatitis B is part of my answer. And now, if you wish me to limit myself to HIV by the nature of your question, I'll be happy to talk about HIV.

Q: Just to clarify, I'm asking you for all the ample evidence that supports your view that HIV is transmittable from patients to health care workers and from health care workers to patients in the invasive health care setting without in any way restricting

whatever ample evidence you think exists that may concern any disease or anything that you think is important.

A: The ample evidence that supports the transmissibility of HIV from patient to health care worker and from health care worker to patient is as follows: A cluster of cases of HIV transmission occurred in the State of Florida, initially

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involving the first patient that was documented by DNA testing ever who was Kimberly Bergalis. And subsequently there were five others that were all documented as having HIV transmitted from a dentist, Dr. David Acer, to five patients in Florida.

Dr. David Acer was a dentist who was HIV/AIDS infected. And all patients were DNA matched and by documentation were determined to have received the AIDS, the AIDS virus from Dr. Acer. To that there is no disagreement in the scientific literature. The CDC convened a conference in February of 1991 in Atlanta to discuss this finding. The conference was concerning itself with blood-borne disease transmission, including HIV and hepatitis B. The primary source of discussion at that conference which I attended and I addressed was the Florida example and what it meant.

And the CDC at that time came up with estimates that in fact although this was the first documented case as determined by DNA testing, the probability was, according to CDC mathematical modules, that there were up to 128 cases, according

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to the mathematical module employed by the CDC, that probably occurred prior to Kimberly Bergalis. And other statistical efforts were put forward to anticipate what might occur in the future.

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... breaching of the anatomical integrity of the tooth with the gum. That could be anything from simple cleaning of the teeth, to extraction of the teeth, to repair of the teeth, to repair of the gums, to oral surgery of the mouth, to pedicle grafts, to endodontia, periodontia, orthodontia, pediodontia, and all of the above.

Q: You consider the cleaning of the teeth to be an invasive procedure?

A: Certainly.

Q: And you believe that's consistent with the consensus of the medical community?

A: Speaking as a patient, my teeth bleed. And as a patient -

MR. McCARTHY: Excuse me one second.

(Witness and attorney confer.)

A: Please repeat the question and I'll

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answer it more concisely.

(Previous question read back.)

A: Yes.

Q: Do you consider dentistry to be more invasive than other health professions?

A: Yes.

Q: Do you consider dentistry to be the most invasive profession in the health area?

A: Yes.

Q: Do you consider the work of a dentist to be more invasive than that of a surgeon?

A: Yes.

Q: And you consider the standard procedures of a dentist to be more invasive than a person who takes blood?

A: Yes.

Q: In Paragraph 6 of your report, the last sentence, you refer to a policy of the American Medical Association; is that right?

A: The AMA is the American Medical Association.

Q: And in the last sentence of Paragraph 6 of your report, you refer to a policy of theirs; is that right?

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A: Yes.
Q: Do you agree with the portion of the policy that you quote in the last sentence of Paragraph 6 of your report?
A: Absolutely.
Q: Turning to Paragraph 7 of your report on page 2, when you refer to tuberculosis, you're making reference to myobacterium tuberculosis; is that right?
A: To what?
Q: Is that the agent?
A: What?
Q: Myobacterium tuberculosis.
A: I believe you mean Mycobacterium.
Q: Let me point you to Paragraph 18 of your report on page 3. Am I correct that you at the end of that paragraph refer to Mycobacterium tuberculosis?
A: That's what I said.
Q: That's what you're referring to in Paragraph 7 as well?
A: In terms of the offending organism?
Q: Right.
A: Yes.

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Q: What is that?
A: Before I answer that, I would have to qualify by saying that there are other forms of Mycobacterium that are involved other than Mycobacterium tuberculosis.
Q: In Paragraph 7 when you refer to the risk of tuberculosis, are you referring to Mycobacterium tuberculosis?
A: Not necessarily only Mycobacterium tuberculosis.
Q: What other form of tuberculosis are you referring to?
A: Mycobacterium aviam intracellulare complex.
Q: Anything else?
A: No.
Q: The second variety you just discussed, how is that transmitted?
A: Mycobacterium aviam complex?
Q: I'm going to call that the second type; is that okay?

We'll refer to that as the second type?
A: It might be easier to call it a non-tuberculosis form of Mycobacterium, because it

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is not tuberculosis.
Q: If it's not tuberculosis, are you sure that you're referring to it in Paragraph 7 when you talk about the risk of tuberculosis?
A: I guess it's partly the way I understood the question and when you injected the word Mycobacterium. If we restrict it to just tuberculosis, we're talking about only Mycobacterium tuberculosis. And I'll apologize for going off on a tangent with Mycobacterium aviam complex.
Q: I'm trying to find out what you're referring to in Paragraph 7 of your report.
A: That is Mycobacterium tuberculosis.
Q: Solely?
A: Solely.
Q: What is that?
A: What is Mycobacterium tuberculosis? It's a bacteria. It's classified as an acid-fast bacteria which means staining technique. It's a bacteria which is the most prevalent cause of bacterial death in the world today. 3 million people die of tuberculosis globally each year. 8 million become infected. And it is a very rapidly

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expanding epidemic, not only in the United States but globally, primarily linked to the global pandemic of HIV.
Q: Let me direct -I thought you were finished.
A: You asked what's tuberculosis. Tuberculosis is spread by droplet infection. It is casually spread. It can be spread by sneezing, coughing, spitting, even laughing or speaking loudly, if one understands that it's spread by the droplets that are spewed out from the mouth. It can also be spread by other methods which are far less common. It can be spread by blood.

It can be spread through draining sinuses, lymph glands, all sorts of lesions. But the primary spread is through the pulmonary, through the lungs and in droplet form, and I might add through laryngeal tuberculosis as well. It affects in the United States - about 150 million people in the United States are infected with the Mycobacterium tuberculosis germ. And the vast majority of these people are in what is called the latent face [sic].
I don't know whether you want me to

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go on with this or is that enough, because if you wish for me to go on, it would be a long discourse about tuberculosis. But I'll leave it up to you what questions you would like to ask.

Q: What is the latent phase of tuberculosis?

A: The latent phase of tuberculosis is where the germ resides in the body in a non-active form and lies dormant. It's an infection for life, and like HIV or herpes, it's there for life. And it can reactivate itself under given conditions.

Q: And you said that approximately 150 million people in the United States have some form of tuberculosis?

A: Have active TB.

Q: Which is the same as the latent variety?

A: Yes.

Q: And when a person has the latent or inactive variety of tuberculosis, they are not contagious; is that right?

A: They are not contagious.

Q: And approximately how many people in the United States currently have active or contagious TB?

A: The estimate is that about 10 percent or

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close to 10 percent, anywhere between 7 to 10 percent will eventually activate into an active form of TB. When and if that occurs is dependent on the condition of the patient. But if one, for example, if we have a resident HIV population which CDC affirms is

between 1 and 1 and a half million patients, then it can be assumed that about 100,000 of these patients have TB. That's about 10 percent. And a significant proportion, as I mentioned earlier, of active TB emanates from HIV-positive patients.

Q: So it's your estimate that 10 percent of the persons with HIV have tuberculosis?

A: Latent tuberculosis.

Q: So 90 percent of the persons with HIV don't have any form of tuberculosis?

A: That's the best guesstimate. But in fairness, because HIV is not reported in 25 of the states - there's only one state in the nation, namely Connecticut, that keeps registries on both HIV and TB. So it is correct to say that the incidence of TB is really unknown in HIV individuals because of confidentiality laws.

Q: For purposes of your expert opinions in

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this case, what assumption if any are you making about what percentage of persons with HIV have some form of TB?

A: A very large proportion of patients with HIV have Mycobacterium avian complex. It's a Mycobacterium, same genus and can cause serious disease. It's also a precursor of TB, Mycobacterium tuberculosis. Although it's a different germ, it's in the same family. There is no reliable statistic, unfortunately, about the incidence of bona fide TB in the HIV community because of confidentiality laws. And I can't give you that answer, because I don't know that. But what I can give you -

Q: If it's responsive to my question, please give it to me.

A: It is responsive to your question. What I can give you is the fact that a significant number of new cases of TB are coming, are emanating from the HIV community. And, furthermore, it's not just a reactivation of this latent form that I've described to you. It's actually transmission from person to person, with a significant portion being, with a significance [sic] proportion of multiple drug

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resistant cases being within the HIV community.
Q: Is it fair to say that based on current scientific knowledge, most people who are HIV positive do not have tuberculosis currently?
A: Yes.
Q: And it's your testimony that people who are HIV positive are more likely to become infected with tuberculosis than the average person; is that right?
A: Yes.
Q: And it's your testimony that people who are HIV positive are more likely to become infected with tuberculosis than the average person; is that right?
A: Yes.
Q: Any other groups fall into the category that renders them more likely to have TB than the average population group?
A: By definition, the definition of HIV is the relentless destruction of the immune system. Therefore, anything that destroys the immune system would open up the patient to opportunistic infections, including TB. Having said that, that group of individuals, be it cancer patients, Hodgkin's disease, patients on suppressive therapy for whatever cancer, the elderly, people who live in shelters, that type of situation does not present with the extreme immunosuppression.
These people are immunosuppressed,

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but is does not present with the extreme immunosuppression, relentless destruction, the total disruption of the immune system by HIV where CD-4 cell counts fall to anything approaching zero. That you do not see in the immunosuppressed other groups. Are they more susceptible, yes. Are they as susceptible, no.
Q: Do African Americans have a higher incidence of TB than the average population in the United States?
A: I believe they do.
Q: Do inner-city residents have a higher incident of TB

than average?
A: Yes.
Q: Males have a higher incidence of TB than women?
A: Yes.
Q: Immigrants from third-world countries have a higher incidence rate of TB than average?
A: Yes.
Q: And there are people who are HIV positive who have normal CD-4 counts, correct?
A: Yes.
Q: What assumptions are you making if any,

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about the number of people in the United States who currently have TB in the active phase.
A: Would you kindly rephrase your question in more specific terms? I don't know what you're aiming at.
Q: How many people do you think currently live in the United States and have active TB?
A: The number of cases that were reported last year, if that's what you mean, was of the order of about 30,000. I maybe off by a few thousand, but between 25,000 and 30,000.
Q: That's the total number of people in the United States having active TB last year?
A: I believe it's in that order. As I said, I'd have to look up the figures. They're easily researchable, but it's of that magnitude.
Q: And most of these people are not HIV positive, correct?
A: Most of those are not HIV positive.
Q: You agree that a dentist needs to be alert to the possibility that a patient may have active TB?
A: Absolutely.
Q: And a dentist needs to be trained in

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identifying persons who are likely to have TB, correct?
A: That is correct.
Q: And what sorts of things should a dentist be looking for

when screening patients for active TB?

A: Well, what they should be looking for and what they're trained in, you can't look for something if you're not trained. And in my opinion the field of dentistry has been remiss and deficient in the field of infectious disease training. Having said that I won't belabor the point unless you ask me to, but having said that the dentist has to employ the skills, judgment and knowledge of how TB works, what its ramification are, how it impacts on a patient that has other diseases like diabetes or a host of other diseases.

So he or she will be called on to exercise their judgment about a serious, casually spread disease that in my opinion they are is not equipped to handle. Even though Dr. Bragdon, who is educated more than most, has the highest of intentions to help his patients, but by his very

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training or lack of it he is incapable without help, without expert help, to evaluate patients properly who have the propensity for TB.

Q: So you think Dr. Bragdon should consult with an outside expert concerning all the groups that have a higher than average risk for TB with respect to whether that person should be referred for TB treatment?

A: No. If you're referring to the groups with HIV, yes, he should consult with outside experts with regard to TB, most certainly. With regard to a host of patients that everyone sees in their everyday practice who are potentially immunocompromised, there are all gradations of immunocompromised patients.

And the ordinary patient who is immunocompromised, the elderly, the patient with diabetes, the patient who had Hodgkin's or whatever, these are not your high-risk patients. They are at higher risk than those who are not immunocompromised, but they're not at the enormous risk of 40 times of the general population that the HIV patient is, because of basic definitions and common sense.

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The HIV virus is the relentless, is the key word, is the relentless disruption of the immune system. Immunocompromised patients are not relentlessly being destroyed as far as their immune system is being destroyed.

Q: Do all people who test HIV positive have a destroyed immune system?

A: No.

Q: It might take 15 years, right?

A: It might take two.

Q: It might take 15, right?

A: It might take 15.

Q: When Dr. Bragdon gets a patient who is not in any of the risk groups, should he make some effort to screen for active TB?

A: Are you suggesting no one in a risk group, even HIV? You said in no risk groups.

Q: He has a regular patient who's not in any of the risk groups for having higher than average incidence rate of TB. Should he still be alert and screen for active TB?

A: Including HIV?

Q: When Dr. Bragdon sees a patient, should he always screen for active TB?

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A: No.

Q: And how does he know when not to screen for active TB, in your opinion?

A. Dr. Bragdon is capable of taking a history. He's capable of inquiring about the complete medical history of the patient that he is treating. And the whole art of dentistry and medicine is primarily an excellent history followed through with appropriate, in the case of dentistry, procedures.

And to divorce one from the other would be the worst of all worlds in that you can't computerize a judgment of a history. And Dr. Bragdon will have to rely on his good judgment as to whether a patient is in need of such testing or whether the patient needs a test for

syphilis or whether the patient needs a test for whatever.

Q: When exercising your good judgment, don't you follow some protocols or standards when exercising that judgment in screening for active TB?

A: If you're going to screen for active TB, yes.

Q: And you don't think Dr. Bragdon should be

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screening all his patients for active TB?

A: No.

Q: If he wanted to screen for active TB, what should he look for?

A: Again, from a medical point of view, you look for symptoms and you look for signs.

Q: What are the symptoms and signs of active TB?

A: Active TB might present itself with weight loss of unexplained origin, night sweats, cough, signs of anemia. Active TB may present itself with a person who is spewing up blood, called hemoptysis. Active TB may present itself with extrapulmonary symptoms or signs that relate to other organs. And, of course, active TB may have signs that are associated with laboratory tests, namely a tuberculin test which is positive.
In the case of immunosuppressed patients it may be negative even though the patient is sick. Or the patient may culture out TB on appropriate testing for the germ itself by culture techniques. And those are the main arenas. The chest X-ray may show something if there is a pulmonary lesion. It may not, even though the

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patient has active TB. And particularly in the HIV-infected individual, negativity does not preclude an active case of TB.

Q: Is it your opinion that a dentist should assume that every HIV-positive patient has active TB?

A: It's my opinion that a dentist should assume that every HIV-positive patient has the potential to have active

TB.

Q: And if an HIV positive patient presents with no other signs or symptoms of active TB, in your opinion, how should that dentist proceed with respect to that patient?

A: That's a judgment call, and there's no protocol written for that. The CDC says that if you suspect active TB, then you should refer that patient for expert treatment. That's what the CDC says. How you suspect that is obviously on nobody's computer screen. It's in the mind of the health care giver, and I can't answer that by any quick fix other than that it's in the judgment of the educated practitioner.

Q: Is there any standard or factors that should inform the wise exercise of that judgment?

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A: Yes, if there were signs or symptoms of TB.

Q: I just said assume there are no signs or symptoms of TB.

A: And there are no standards for that except if the patient is at a very high risk. And by public health definition, an HIV-infected patient is a high-risk patient for TB. Therefore, it will depend on the practitioner to decide whether or not he or she wishes to screen that patient or whether he or should say, Be screened by your local doctor or by your public health authority or whatever.

Q: If the HIV-positive person has a primary physician who is handling their HIV status, could the dentist just call that person to get their opinion about whether this person has active TB before proceeding?

A: Certainly if the patient will agree to that arrangement.

Q: Another possibility would be ask the person to have a TB test; is that right?

A: Certainly.

Q: Are those steps ones that should be taken

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before the dentist uses all the precautions that are indicated before a patient who is known to have active TB --

A: Excuse me, but your prefacing it by saying skin test. Did you not say to do a tuberculin test first?
Q: Calling the primary physician regarding the status of having a TB skin test, are those steps that should be taken before one starts using all the infection control procedures that are designed for a patient who is known to have active TB?
A: Yes.
Q: Most forms of active TB are treatable; is that right?
A: Most forms are treatable.
Q: If it's treatable, that can be rendered noncontagious within two to four weeks; is that right?
A: It can be rendered noninfectious within a period of weeks, yes.
Q: Let me ask you to turn to Paragraph 8 of your report. How did you calculate the risk of transmission of HIV from an HIV dental patient to

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the others in the dental office?
A: That wasn't calculated by me. If was calculated through many investigators. And it's been recorded in publications I've given you and I dare say others that the risk of transmission is about 0.5 percent or namely about one out of 250 needle sticks or thereabouts.
Q: So are you referring to in Paragraph 8 of your report where the studies concerning the risk of transmission of HIV on a dental or health care worker has an accidental needle stick with a known HIV-positive patient; is that right?
A: Yes.
Q: And that's all you're referring to in Paragraph 8?
A: That's all I'm referring to.
Q: Let me ask you to read Paragraph 10 of your report. In the second sentence you state your opinion that universal precautions are unreasonable with respect to Dr. Bragdon because he is unable to deal with all the associated risks of HIV transmission in his office. To what risk of HIV transmission are you referring?
A: As I just articulated under No. 8 those

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were referring to needles sticks, of course, only. And in No. 10 the risks, of course, can extend itself to cuts, to coughing of blood, which would impact on the mucocutaneous surfaces, whether there could be an opportunity for blood-to-blood or blood-to-bodily fluid, the two-way street between Dr. Bragdon and Ms. Abbott.
And the associated risks in that context as I mentioned before are the tearing of gloves, the cutting of gloves, basically the intervention of blood to blood through whatever mechanism, be it a bleeding tooth socket with Ms. Abbot, an inexplicable nick in her gums and the puncture of Dr. Bragdon's gloves, almost any scenario you can think of in the cavity of Ms. Abbott's mouth that would interact with Dr. Bragdon's blood. And Dr. Bragdon can make mistakes.
Q: Are those all the risks of HIV transmission that you believe render it unsafe to practice general dentistry with an HIV-positive patient in a dental office?
A: Those are the known risks that I would consider. The unknown ones, I haven't, none of us

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have learned about yet. But I would be remiss if I didn't indicate to you that those unknown risks, because a paradigm of other blood-borne virus, hepatitis B, clearly exist.
Q: You're positive that these unknown risks exist?
A: I'm positive that they exist, yes.
Q: And that's part of the basis for your opinions in this case?
A: Yes.
Q: These risks of transmission of HIV, do they also exist when a dentist performs general dentistry work on an HIV-positive patient in the hospital?
A: They do.
Q: But you agree that it's reasonably safe for Dr. Bragdon to perform general dentistry work on an HIV-positive patient in the hospital?

A: I believe it's generally safe with a reduced risk.
Q: How is that risk reduced in the hospital?
A: It's reduced in the hospital firstly because Dr. Bragdon has the time to deal with that patient. And time is a critical factor in this,

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shall we call it, debate, because Dr. Bragdon sees an average of 20 to 40 patients a day. In all fairness to Dr. Bragdon, being the careful, astute dedicated doctor that he is, cannot do justice to an HIV-infected patient in his office with 15 patients waiting behind that patient.
The time factor which is in concert and compliments the comfort and confidence factor are absolutely essential to Dr. Bragdon carrying out universal precautions in a hospital setting with the confidence that he's doing the right thing and not causing injury to himself or to his patients.
Q: Any other ways in which performing general dentistry work in the hospital reduces the risk of HIV transmission?
A: No.
(Witness and attorney confer.)
MR. WEBBERT: I'm greatly concerned about this repeated practice of having conversations after I ask questions. And in particular I'm concerned that he's going to backtrack on his last answer, which was quite unequivocal, after consulting with his counsel. I

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request you not do that; and if he does it again, I'm concerned we're going to have a dispute if he changes his testimony in the future.
MR. McCARTHY: I believe I have a right to consult with my client. I believe I have a right to ask for a break when there's no question pending. I have consulted with my client. Putting that aside, I have the right to consult with my client. If you think I don't, we really should discuss that, because I don't have any

doubt but I have that right. As one lawyer said, I'm not a potted plant.
MR. WEBBERT: Does that mean you can do anything that you want?
MR. McCARTHY: No. It means I can talk to my client when there's no question pending. I might as well go home if I can't.
MR. WEBBERT: There are precedents that indicate you're not supposed to coach the witness during deposition. You should prepare him beforehand. And I'm indicating for the record my concern about that repeated practice and my concern that his testimony is going to change based on the conversations with counsel. I have no objection to

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the distinction between going out of the room and doing it in here. That's not the point.
MR. McCARTHY: All right. Let's take a break. I'll go out of the room and talk to him. If you want it done that way, that's fine.
MR. WEBBERT: I just made it clear that's not the way I want it done.
MR. McCARTHY: I'm taking a break, ...

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...
A: No.
Q: Why are you not a member?
A: It's another organization like the AMA

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which you pay your money and you join. And I just am not - well, it does no service to me to join innumerable organizations with no meaning as far as I'm concerned as to the productivity that I can perform at this stage in my career.
Q: Or for the last 35 years, correct?

A: Well, yes, in the sense that I'm a free individual that chooses what I feel is best to serve the public or public policy.
Q: That society has been around ever since you've obtained your medical degree, right?
A: Certainly.
Q: And you've never chosen to become a member; is that right?
A: That's correct.
Q: Were you ever elected a fellow of that organization?
A: You can't be a fellow if you're not a member.

MR. McCARTHY: What organization are we talking about?

MR. WEBBERT: Infectious Diseases Society of America.

Q: Is that right, Doctor?

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Is it fair to say that the National Foundation for Infectious Diseases is primarily a fund-raising organization?
A: No.
Q: You're the chief of tropical medicine at the Seton Hall University Graduate School of Medicine; is that right?
A: Yes.
Q: How large is the tropical medicine department at that institution?
A: The tropical medicine department is basically me. They wanted expertise to teach residents.
Q: So I take it you're both the chief and indian, and there's nobody else around?
A: That's basically correct.
Q: And what do you do as chief of the tropical medicine department?
A: On a demand basis, I lecture to the residents at the graduate school about infectious and tropical diseases.
Q: Average of what, once a year or less?
A: Something of that magnitude.
Q: And that's for a couple of hours that you lecture?

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A: Yes.
Q: Do you receive any salary at all for your position at Seton Hall?
A: None at all.
Q: Have you had any regular patients since 1986?
A: No.
Q: Have you been consulted with about the care of patients since 1986?
A: No.
Q: Have you ever treated any HIV patients?
A: No.
Q: Have you ever treated any patients with TB?
A: Yes.
Q: When is the last time you did that?
A: Prior to 1986.
Q: Did you treat them in your office?
A: Some.
Q: Did they have active TB?
A: Some.
Q: What precautions did you take in your office when you were treating patients with active TB?

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A: Well, once I knew they were active, then I would treat them in a hospital, once the diagnosis was made on an outpatient basis. I would not treat a patient on an ambulatory basis with active TB in those times.
Q: So once you diagnosed that it was active TB, you only saw them in the hospital?
A: That's correct.
Q: And what precautions did you take in the hospital with respect to infection control?
A: Mask, gown.
Q: Any other precautions that you personally took?
A: No.
Q: Any other precautions that were used to reduce the risk of transmission of active TB?
A: Not in those days.
Q: In the capacity that you've served since 1986, do you have occasion to interact with HIV-positive patients?

A: Yes.
Q: Do you take any infection control precautions when you interact with those patients?
A: Yes.

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Q: What precautions do you take?
A: Wear a mask, gown, gloves.
Q: When did you start taking those precautions?
A: Early on in the epidemic. I would say from '85 onwards.
Q: Did you wear a mask, gown and gloves when you interacted with Kimberly Bergalis after you knew she was HIV positive?
A: No, I did not.
Q: Why not?
A: Because in those days of knowledge, the concept of TB, which was the only concern, was not as flagrant or as overt as it is with today's state of knowledge. And I may have misstated by saying I wore a mask after '86. It may have been '90 or '92, somewhere in that area..
Q: If you were consulting with Kimberly Bergalis today, what precautions would you take when examining her?
A: I would wear a mask, gown and gloves.
Q: Any other precautions you would take?
A: Well, I would suggest that I would examine Kimberly in a hospital setting which

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provided for the same type of care that Dr. Bragdon is aiming toward for HIV-infected patients, not necessarily aimed at the HIV only, as mentioned to you. The time factor is a very important one. But also for the concurrent factors, reverse air flow, UV light, the possible use of respirators, in order to protect the HIV-infected patients of what we know today, complications that we didn't know about yesterday.
Q: So if you were a medical consultant on an HIV-positive person today, you would only see them in the hospital?
A: Not necessarily. Not necessarily.

Q: It would depend of how likely you think it is that they have active TB?
A: Yes.
Q: What sort of factors would inform your judgment in that regard?
A: That's again my judgment. And this is the art of medicine, not the science of medicine. And it's predicated on my -- you asked about me -- on my training, my experience. Although I quite rightly told you I've treated no HIV patients, I've seen hundred of them, not treated them, but

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hundreds. And I've seen them around different parts of the globe.
The ability to deal with patients at any given time and the risks one is willing to take as a physician are judgment calls. You'll find some physicians that work in very prominent TB hospitals that wear no masks. And when asked about it they'll say, "Well, I should, but I don't."
Q: What factors should inform a responsible health care worker's decision about whether to treat an HIV-positive patient as if they have active TB?
A: It's really a judgment call as to where the physician feels that HIV patient is in terms of - although all HIV patients can have TB, not all HIV patients are created equal. And it comes down to an exercise in judgment.
Q: And should that judgment be informed by an individual assessment of the factors peculiar to the particular HIV-positive patient the health care worker is dealing with?
A: I'm sorry, rephrase that.
Q: When the dentist or health care worker is making the judgment about whether or not to treat

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an HIV-positive patient as if they have active TB, should they attempt to make an individualized assessment of the particular factors relating to that

patient?
A: Yes.
Q: For example, you would look for symptoms of active TB, correct?
A: Yes. You would look for symptoms and signs of active TB. But if a sign can only be demonstrated by a chest X-ray, which you don't have in your dental office, and if you really suspect this patient of having active TB, then it's incumbent on you to get this patient to a setting where that can be carried out.
You might say, Have your local GP do it or have someone else do it. Have an infectious disease specialist do it. But if I were a conscientious dentist like Dr. Bragdon and I wanted to follow through my patients from beginning to end for their dental well-being, then I would want to follow them into a setting where I could treat them as a complete patient. And the word complete whether you spell it l-e-t-e or l-e-a-t, has a great significance to it.

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The completeness of medical care by Dr. Bragdon I think is one of his most outstanding attributes. I passionately believe that. And I think he's entitled to that judgment of completeness in following through his patients. Is HIV in a hospital setting necessary for the HIV to have reverse air flow, UV lights, all sorts of respirators, no. But the possibility of other infection that is high on the list of Dr. Bragdon's hit list is very important.
Now, there are certain things that I'm not qualified to talk about and Dr. Bragdon is, namely about scrubbing floors, about having second assistants because there's less interchange of instruments, about all these surgical aminities [sic] that he feels are a necessary prerequisite to a hospital setting. I'm not knowledgeable about that arena that he deals in every day.
But I would absolutely support his right to judge that patient, even if it's to err, as the AMA says, on the side of being overly cautious. Why doesn't he have the right to be overly cautious in favor of himself or the

patient if that's his good judgment?

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Q: Are you referring to the AMA policy that you quote in Paragraph 6 of your report?
A: Yes.
Q: That's the one that says the doctor should err on the side of patient protection?
A: Yes.
Q: Is your expert opinion in this case based on the assumption that Dr. Bragdon in good faith wants to treat HIV-positive patients?
A: Yes.
Q: And that he has made good faith efforts to locate off-site facilities that will enhance his ability to take care of HIV-positive patients?
A: I don't know the extent to which he has located off-site facilities. In all candor, I know he has drawn a blank on certain attempts to locate off-site facilities as evidenced by the only documentation I have, which is his deposition. But, do I believe he is serious and passionate about treating HIV patients just like every other patient, absolutely.
Q: And that's an important assumption in your expert opinion.?
A: Yes, it is.

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Q: And you agree that Sidney Abbott deserves to get her dental care taken care of?
A: No question about it.
Q: And that doing that is an important goal of the dentist?
MR. McCARTHY: Object to the form of the question.
A: Well, Sidney Abbott can't have her dental work done without a dentist. So, therefore, it's not only a goal it's an obligation of a dentist to perform that. I have no problem with that at all. However, I do have a serious problem with the inability of Dr. Bragdon to exercise his judgment in taking care of Sidney Abbott.

Q: But you agree he has an obligation to make sure she gets her dental needs taken care of?
A: Absolutely.
Q: And that can be done without exposing him to an unreasonable amount of risk?
A: I think the risk is real to Dr. Bragdon. He is willing to take that risk. He wants to take it under the maximal protection to himself, his patients, his staff and for the betterment of the patient. How can you argue about discovery about

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medical knowledge of a patient? And if you go in for an examination and you do X, Y and Z exams and they're superfluous, you would normally say. Well, I'm glad you found everything was negative. The purpose is in the form of insurance. We don't want to exercise our life insurance policies tomorrow. We want to stay alive.
Q: But you agree that that routine dental treatment can be provided safely to HIV-positive patients?
A: I believe that routine dental treatment can be provided to HIV-positive patients, but always, because of the nature of HIV, with a degree of risk. The risk is low. The risk is in most cases preventable. But the risk looms very large if you don't have the protection that Dr. Bragdon or anyone else providing health care is deserving of to protect himself and the patient.
Q: But you're not taking the position that it's so inherently dangerous to provide general dental care to HIV-positive patients that dentists should not be required to provide such care?
A: O, no. I agree with that.
Q: What is the Sanford F. Kuvin Center for

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the Study of Infectious and Tropical Diseases?
A: The Sanford F. Kuvin Center for the Study of Infectious and Tropical Diseases is an official center for research at the Hebrew University Medical School

in Jerusalem, Israel. It …

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… me about the Morvan case and would I give them a report, which I did.
Q: Is it possible that you called up the attorneys first to initiate that relationship?
A: Good lord, no.
Q: You're positive about that?
A: I'm not only positive, I'm certain.
Q: Let me ask you to look at what we've marked as Kuvin Deposition Exhibit 2. It's a report that the defendant provided us earlier in the case.
A: Yes.
Q: You've reviewed Deposition Exhibit 2

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carefully in the past, correct?
A: I didn't quite hear you.
Q: You've reviewed this report carefully before today, correct?
A: Yes.
Q: Do you agree with everything in this report?
A: Not necessarily.
Q: In Paragraph 2, the report asserts that HIV is highly infectious. Do you agree with that?
A: That's the not necessarily.
Q: You disagree with that?
A: I disagree with that.
Q: In Paragraph 4 there's a discussion of regular monitoring of CD-4 cells. You believe that's indicated when a dentist provides general dental services to an HIV-positive patient?
A: I think it is. I think it's a meritorious recommendation. Again, this is a judgment call. It is certainly a recommended recommendations for treating an HIV patient outside of a dental setting. And if the dentist is coerced, as he is under current circumstances - I hope it will change - but if he is coerced into treating a

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patient with HIV with the same medical obligations, then he too has to follow those same general parameters of testing a patient for CD-4 cell counts, because he too is really being made in to treating a dental patient as a medical patient. And as I indicated to you before, I think it's inappropriate, unfair, unwise and to the worst detriment of both the caregiver and the patient.

Q: If a dentist has a patient who comes in who is HIV positive who indicates she has a primary physician who is handling her HIV condition, what need is there for the dentist to do his own CD-4 testing?

A: Well, I can't give you - and I don't want to sound facetious. If I went in to a doctor and I complained on chest pain, and he said, "Go see a specialist." And the specialist said, "Well, why are you telling me that? You already told it to the first doctor." It's the transfer of responsibility then moves on to Dr. Bragdon because he is then in essence the primary care doctor, not legally. But if he's going to be dealing with diseases like TB, cytomegalovirus,

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staph, strep, toxoplasmosis, whatever the ramification may or may not be, he is put upon to learn as much about that patient as he possibly can. And a CD-4 cell count in today's technology is one of those parameters.

Q: It's your opinion that for a dentist to provide competent, general, routine dental services to an HIV-positive patient, that they must take over the primary care of the HIV condition and all its possible manifestations?

A: No. I don't think they should take over the primary care. But when that patient comes under their care, then they are the chief. And what Dr. Bragdon, unless I'm misconstruing this whole case, what Dr. Bragdon wants to do is to continue to treat that patient under his care, provide dental treatment. But in order to do that, he wants to do it in a setting where the expert care may

be available. But he's still in charge of the dental aspects. But it's being put upon him to deal these other problems if they arise.

Q: Why would a dentist need to know the CD-4 count to take care of a cavity in an HIV-positive patient?

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A: Well, the CD-4 count is merely a reflection of the immunocompromised state of the patient. And if a CD-4 count is at abnormal levels for whatever reason, it means that Dr. Bragdon has to be cautious about what diseases are floating about his operatory from himself, his staff, his patients, so as to not put his patient in jeopardy; and, secondly, to worry about what the patient has in addition to her HIV that may put him in jeopardy. Again, it's his right to know what harm can befall him and what harm can befall the patient, because this is a two-way street.

Q: Do you agree with Dr. Bragdon that there should be annual testing for TB of all HIV-positive patients?

A: Yes, I do.

Q: If they had a recent test that was negative, would that indicate that the patient could be treated as if they did not have active TB?

A: No.

Q: Do you agree with him that there should be an annual test for syphilis of all HIV-positive patients before a dentist performs routine dental care on that patient?

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A: I don't feel uncomfortable with that. I certainly don't feel it's obligatory. The concept is that if the CD-4 cell count is low, the syphilis will progress at an abnormal rate of infectivity, as it were, as would any germ. In other words, if the CD-4 cell count is compromised, syphilis, TB, CMV, toxoplasmosis, anything you can think of will put the patient at greater risk. Syphilis happens to be communicable to other people. I don't feel uncomfortable. I personally don't see it as

obligatory to add it.

Q: Given your concern that HIV-positive patients can test negative for TB and still have active TB, shouldn't we quarantine all HIV-positive patients in this country?

A: No. I'm absolutely opposed to quarantining all HIV patients in this country, because HIV is not spread casually. And TB is. Should we quarantine TB patients? They are quarantined under the law, and that's the rub. Why isn't the law applicable to HIV the same way it is to TB? So, no, I clearly do not see any need to quarantine a patient with HIV.

Q: Unless they test positive for TB?

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A: And only then if they fail to take their medicine. And then only then if they take their medicine and they-re multiple drug resistant.

Q: If you have an HIV positive patient, even if they test positive for TB, you can treat it and then give then the routine dental care in the dental office, right?

A: Yes, you could.

Q: Turning to page 2 in the report, it lists a number of things -

A: Before I leave that, you can give them the routine care in the dental office, if the presumption is to be followed through to its correctness, the ability to diagnose the TB would be done in a hospital setting. And it would therefore be cost effective, shall we say, to treat the patient while they're in the hospital setting for the dental problems after they've been rendered noninfectious to TB.

Q: Wouldn't it be cheaper to provide dental care in a dental office than in a hospital?

A: On the face of it, of course.

Q: Isn't it cheaper to wait the two weeks to render the TB inactive and then do the treatment?

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A: It could be, or it could be a lot more expensive, depending on the patient you're dealing with. Again,

we're back to judgment.

Q: Turning to page 2 of the report, do you agree that air filtration does not reduce the risk of HIV transmission?

A: Air filtration does not reduce the risk HIV transmission, that's correct.

Q: And do you agree that the use of ultraviolet lights -

A: Let me, please, under the current state of knowledge, because in all fairness, the concept of aerosol spread has been repeatedly raised. It has not been put to bed. And I cited for you the Morbidity and Mortality Weekly Report of only a few weeks ago that said one should treat hemorrhagic fever as if it could be spread, namely, the Ebola virus, as if it could be spread by aerosol transmission, even though there's no evidence for it. So, I would say yes, air filtration under current knowledge will not be meaningful, with the cavea: that that is still under a state of discovery.

Q: Do you agree that the use of ultraviolet

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lights would not reduce the risk of HIV transmission?

A: Ultraviolet lights are germicidal, and it would be predicated on what I just said. It's advocated against TB. It is not a known method of dealing with HIV.

Q: Do you agree that using negative pressure would not reduce the risk of HIV transmission?

A: Yes, with the same disclaimer about if aerosols ever come to light.

Q: Based on the best current scientific knowledge, the use of negative pressure would not reduce the risk of HIV transmission, correct?

A: Yes.

Q: And based on the best current scientific knowledge, the use of respirators would not reduce the risk of HIV transmission, correct?

A: Yes.

Q: And the use of a sterile water supply would not reduce the risk of HIV transmission, right?

A: I don't know, but probably not.

Q: And the use of hair coverings would not reduce the risk of HIV transmission, would it?

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A: It would not, in my opinion.
Q: Would the use of a face shield to protect skin areas not protected by masks and safety glasses from droplet and splashes reduce the risk of HIV transmission?
A: Yes, it would.
Q: Could a face shield be used by a dentist in a dental office?
A: Could a face shield, yes.
Q: Would double gloving reduce the risk of HIV transmission ?
A: Yes.
Q: Could double gloving be done by a dentist in the dental office?
A: Yes.
Q: Would the changing of the gloves every 30 minutes reduce the risk of HIV transmission?
A: Yes.
Q: Could that procedure be done in a dental office?
A: Yes.
Q: Do you believe the treatment - let me refer you to Item X on page 2 of Deposition Exhibit 1. Do you believe that procedure would reduce the

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risk of HIV transmission?
A: "Treatment should be carefully planned." Is that what you're reading?
Q: Yes.
A: Would you kindly repeat that? I didn't understand your question.
Q: Would following the procedure set forth in Roman Numeral X on page 2 of Bragdon's report reduce the risk of HIV transmission.
A: Yes, it would.
Q: Could it be done in a dental office?
A: Yes, it can.
Q: Would the use if disposables reduce the risk of HIV transmission?

A: Yes.
Q: Could it be done in a dental office?
A: Yes.
Q: Would the covering of shoes reduce the risk of HIV transmission?
A: Possibly.
Q: How so.
A: If there were a great exposure of blood or bodily fluids through nicking of an artery, let's say, and there was a genuine splattering of

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blood, it is conceivable that just as much as hands can be contaminated with blood, hands have lesions on them. So you're shielding the shoes of a foot that have lesions on them and could be contaminated with HIV, and that's the reason for the covering of shoes.
Q: So the blood from a dental procedure would flow into the dentist's shoes, go through the shoe and the sock to a cut in the foot and transmit HIV?
A: That's a theory.
Q: Any documented evidence that that has ever happened?
A: No.
Q: Could shoes be covered in a dental office?
A: Yes.
Q: Would the use of hospital scrubs reduce the risk of HIV transmission?
A: Yes.
Q: Could that be done in a dental office?
A: Yes.
Q: Would the changing of the hospital scrubs after the procedure has been completed reduce the

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risk of HIV transmission?
A: Yes.
Q: Could that be done in a dental office?
A: Yes.
Q: Would placing the hospital scrub in an appropriate container or hamper after the procedure has been

completed reduce the risk of HIV transmission?
A: Yes.
Q: Could that be done in a dental office?
A: Yes.
Q: Would the use of a second assistant in a dental procedure reduce the risk of HIV transmission?
A: Yes.
Q: How so?
A: There's less exchange of instruments between the dentist; and the less chance for human error, the better off the operator is. In operating theaters - and that's one of the reasons for going into a hospital setting - you do have a second assistant for that very purpose. Place yourself in the operating room - I don't know if you've had the privilege of being in one - but

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there's a delegation of authority that is not present in an - I don't want to demean the office of Dr. Bragdon - but ...

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... is a different report (Exhibit 10 is marked for identification.)
Q: Let me show you what I marked as Kuvin Deposition 10, which is a supplemental report of Dr. Molinari.
A: I have never received this particular report.
Q: Let me show you Exhibit 10 and ask you if you've seen that report.

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A: Yes. This is the report that I have received. I'll be happy to read this if you wish, but I have not received this report.
Q: Why don't we return to the question you were answering before it occurred to you that you hadn't seen Exhibit 9 before. You were explaining what your HIV transmissions discussions were about with Dr.

Molinari?
A: Yes. That was a panel discussion meeting in New Jersey. I don't remember where. It may have been New Brunswick. I can't really recollect. And amongst the panelists were Dr. Molinari and Dr. Cottone. Dr. Cottone. as you know, is a coauthor with Dr. Molinari of books on infection control in dentistry. And Dr. Molinari, who is a Ph.D., was articulating the Kimberly Bergalis case and his perception of it at the time when that case was being hotly debated as to its authenticity, namely, did it really occur.
Because most dentists disbelieved it. Most dentists had what I would call and I said so, disregard for medical facts, disbelief of the case. And the discussion - I was not part of the panel, but I certainly asked questions from the

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floor. Dr. Molinari presented a rather correct overview of HIV, if I remember correctly. And I do remember this, however, that Dr. Cottone spoke and -
MR. McCARTHY: Do you remember the question?
THE WITNESS: Yes. It was how do you think this occurred. How do you think the transmission occurred?
A: At which point Dr. Cottone -
MR. McCARTHY: I'm talking about the question that the lawyer asked you. Do you remember the question that he asked you?
THE WITNESS: About Dr. Molinari, what did he say at the meeting, is that correct, at the meeting. Would you repeat the question then?
Q: What did Dr. Cottone say at the meeting that you can recall?
A: Dr. Cottone said that he felt the Kimberly Bergalis case was a myth.
Q: Did Dr. Molinari say the same thing?
A: No.
Q: Anything else of note that Dr. Molinari said during that meeting?

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A: Dr. Molinari didn't deny it either. He didn't disagree with Dr. Cottone.
Q: There is a theory that the dentist intentionally transmitted HIV in that case, correct?
A: There was a theory proposed.
Q: And that has not been able to be ruled out, correct?
A: I would say it has been ruled out, yes.
Q: By the CDC?
A: By the CDC.
Q: The CDC had a theory that because he was suffering from significant symptoms of HIV, that his poor health may have resulted in the transmission of HIV. Are you aware of that theory.
A: No, I'm not aware of that theory.
Q: What is your impression of Dr. Molinari as an expert on HIV transmission?
A: I think he's a well-respected expert on infection control and HIV and other infectious diseases.
Q: Do you have any reason to question his opinion on the transmission of HIV?

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A: I think he's both credible and reliable. I have some disagreements with him as to his perceptions of the transmission of HIV.
Q: What are those disagreements?
A: Well, the disagreements are centered about the risk involved, the significant risk involved in the transmission in the health care setting.
Q: Do you disagree on the quantity of the risk with Dr. Molinari?
A: Yes.
Q: What do you think the quantity of the risk is?
A: I believe that that risk is small but real. Dr. Molinari, in my opinion, believes it's infinitesimal and remote. I can't speak for Dr. Molinari, obviously. He should say that for himself, if he believes that.
Q: What do you mean by "small"?
A: Well, "small" means that 42 health care workers have

gotten HIV. And for those 42 and the 92 others, that's 100 percent. To the individual, that's 100 percent. The tragedy is 100 percent. To Kimberly Bergalis and the other five patients,

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that was 100 percent. But the numbers are small. What's most disturbing is that 60 percent of the HIV-infected people in American today don't know they're infected.
Q: How many?
A: 60 percent.
Q: Haven't you previously said 90 percent?
A: I don't believe I said 90 percent.
Q: Gold's report, didn't you say 90 percent of HIV person's are unaware of their condition?
A: That was then, and this is now. The more recent estimate by the CDC, in all fairness, in May of 1995 as articulated by Dr. Lee before the Congress during hearings conducted in May, and I'm perfectly content with his figures, is 60 percent.
Q: So 60 percent of the HIV-positive persons in this country are unaware of their condition?
A: Yes.
Q: So if they're asked by their dentist if they were HIV positive, they would say, "I'm not"?
A: They would say "I'm not" or "I don't know," one of the two. They wouldn't say "I'm not" because they weren't tested.
Q: So your conclusion that the risk is small

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is based on the assumption that one transmission of HIV would be significant?
A: It's based on more than that. It's based on the mathematical formulas put forward by the CDC which said back in 1991 that an infected health care worker, an invasive health care worker's chance of transmitting HIV to a patient over a seven-year period would be anywhere from 2 to 8 point something percent with a

high of 12 percent if you're in a highly invasive specialty like orthopedics or what have you.
Those figures have been bantered around and contested and debated anywhere from 1 to 40,000, 400,000 procedures. The fact is that the risk is small, no matter what numbers you care to use. But they're real. They're not infinitesimal. They're not remote, and they're not nonexistent.

Q: The statistics you referring to from the CDC is concerning the risk of transmission from the health care provider to the patient, correct?

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...

A: I agree with the second sentence.
Q: Do you agree with the third sentence?
A: I disagree with the third sentence.
Q: Do you agree with the fourth sentence?
A: I disagree with the completeness of the fourth sentence or the incompleteness, I should say, of the fourth sentence.
Q: Do you agree with the fifth sentence?
A: I agree with the fifth sentence.
Q: Do you agree with the last sentence of Paragraph 18?
A: I agree with the last sentence.
Q: Have you reviewed the materials cited in this report on pages 3, 4 and 5?
A: I've reviewed many of these, yes. I cannot state with certainty that I reviewed all of them. But many of them look familiar to me.
Q: Can you indicate what you believe are reliable authorities on HIV transmission, to the extent you're able to render such an opinion.
A: No. 1. No. 2.
Q: These are all reliable authorities on HIV

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transmission?
A: The reliable authorities are No. 1, No. 2, No. 4, No. 5,

No. 7, No. 8, No. 9, No. 10, No. 11, No. 12, No. 13, No. 14, No. 16, No. 17, No. 18, No. 19 (Exhibit 11 marked for identification.)

Q: Let me show you what I've marked as Kuvin Deposition Exhibit No. 11, which is Dr. Craven's report. Are you familiar with Dr. Craven?
A: Only by the material presented to me.
Q: Are you familiar with his reputation as a reliable authority?
A: No.
Q: Have you ever had any personal contact with him?
A: No.
Q: You have reviewed Dr. Craven's report to prepare for today's deposition?
A: I have.
Q: And you reviewed his credentials?
A: I have.
Q: Do his credentials appear to qualify him as an expert on infection control and HIV transmission?

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A: They certainly do.
Q: Do you have any reason to question his credibility and reliability as an expert in this case?
A: Not at all.
Q: Let me ask you to look at what I've marked - let me ask you one more question about your review of Dr. Craven's credentials. Do they appear to qualify him as an expert on the transmission of TB?
A: Yes.
Q: Let me show you what I've marked as Kuvin Deposition Exhibit 12, the report of Dr. Marianos.
A: Right.
Q: You've read that before today's deposition.
A: Yes, I have.
Q: Are you familiar with him?
A: I know of Dr. Marianos.
Q: Do you consider him to be an expert on HIV transmission?
A: Dr. Marianos, to the best of my recollection, is an officer of the public health service in the CDC as a

dentist and has worked in

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research in the dental unit and certainly would be regarded as an expert in HIV.

Q: And on the proper management of dental patients with HIV?

A: I regard him as an expert in his opinion. I don't agree with Dr. Marianos. But, yes, I do regard him as an expert.

Q: And Dr. Craven's credentials appear to qualify him as an expert on the management of patients with TB?

A: They certainly do.

Q: Do you have any reason to question the reliability or credibility of Dr. Marianos as an expert in this case?

A: Not at all.

Q: Do you agree that Dr. Marianos is more familiar with the CDC statistics on the 42 transmissions of HIV to health care workers than you are?

A: Yes.

Q: So you would defer to him on the precise facts of those transmissions?

A: I think that's reasonable, yes.

Q: Based on your review of Dr. Marianos'

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report, what are your points of disagreement with him?

A: You would have to take this down from the top.

Q: Okay, you go through the report -

A: Yes.

Q: - and tell me what you disagree with line by line.

A: On page 4, No. 5, Dr. Marianos states, and I quote, "In 1993 the CDC issued revised recommended infection control practices for dentistry. The 1993 document updates previously published CDC recommendations for infection control."

Q: Instead of reading, could you just tell me when you disagree.

A: Yes. In that 1993 document, the 1993 document articulates the dangers of spread of infectious agents.

And it lists them as cytomegalovirus, streptococci, staphylococci, CMV, HIV, hepatitis B by saliva, by blood, and other methods including droplet infection. And none of this is articulated in Dr. Marianos' description of the 1993 document.

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No. 6, Dr. Marianos says, "No infection control procedures beyond the use of universal precautions are necessary in providing routine dental care to persons with HIV and AIDS." For the sake of brevity, I think we've covered my objections to that statement, namely, that universal precautions do not provide for universal safety. We've spent a reasonable amount of time, unless you want me to go over it again I will, as to why I feel so strongly about that and where universal precautions break down. And, secondly, universal precautions, of course, do not provide for the problems associated with HIV which are absolutely part and parcel of the epidemic and in fact are part of the locomotive driving it.

So I disagree with Dr. Marianos' statement that no infection control procedures beyond the use of universal precautions are necessary in providing routine dental care to persons with HIV and AIDS. If you want further amplification, fine. I'll discuss it with you.

Q: What other precautions do you think should be taken?

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A: I think that patients with HIV/AIDS have to be judgmentally observed by the treating dentist and that patient determined by the good judgment of the health care worker as to what facility, what special facility if necessary, is obligatory for the further safety of the patient, the health care worker, the health care worker's associates and the time and attention that can be given to that patient outside of a dental operatory.

Q: So you believe that the dentist should make an individualized assessment of each HIV-positive patient

to determine what precautions if any are necessary beyond universal precautions?

A: Yes.

Q: And sometimes, based on that individualized assessment, the dentist will determine that additional precautions are needed beyond the universal precautions?

A: Yes.

Q: And sometimes, based on that individualized assessment, the dentist will determine that no additional precautions are necessary beyond the universal precautions to provide routine dental care?

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A: That is also correct.

Q: How about the second sentence of Paragraph 6? Do you agree with that?

A: I disagree with that in that it's an error, in my opinion an error of omission. It's not, the CDC does not go on to articulate the use of infection control procedures except for the fact that in 1995, or I should say in 1994, they have gone beyond this in terms of the referral of patients who are suspected of having TB for further evaluation. And, again, Dr. Marianos makes no reference to that.

Q: What's the cite to the CDC publication that you're referring to ...

A: Dr. Marianos is one of the authors on it. And that's the CDC recommendations in 1994 for tuberculosis control in dentistry, and Dr. Marianos is the sixth author on that publication.

Q: Is that the authority that you're relying on with regard to how dentists should handle the risks of TB when dealing with patients?

A: It's one of the authoritative sources, yes. Would you like me to.

Q: If you've finished expressing your

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disagreement with Paragraph 6, I'd ask you to move on

to Paragraph 7.

A: I disagree with Paragraph 7.

Q: Do you disagree because sometimes you think that additional precautions are necessary?

A: Yes. And that should be the individual judgment of the health care practitioner.

Q: Based on an individualized assessment of the particular patient they're treating?

A: Exactly.

Q: If we've exhausted your disagreement with Paragraph 7, we can move on to Paragraph 8.

A: I wouldn't say you've exhausted it, but we can move on.

Q: No, I want you to have an opportunity to fully express your disagreement. So if you have any other reasons for disagreeing with Paragraph 7, go ahead.

A: Well, let me just say this. Throughout the world it has been recognized since infection control has come under scrutiny that there are specialized centers that are required from time to time. And, for example, I personally have worked at fever hospitals, I've worked at infectious

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disease hospitals that segregate patients. Why? Because they come under better scrutiny, more precautions and greater observation, something that you can't put into a statute or a law.

Namely, by their very presence in that facility, they are handled in a better and a better judgmental way with the comfort and the confidence of the staff involved. If you're at an institution, whether it be the NIH where I used to work, we treated patients differently when they came on the infectious disease floor. When I was a full-time assistant professor at the University of Miami, we treated patients differently when they came under our aegis and medical care, because they required special attention.

If we were dealing with patients by the clock and by appointment, as it were, we would be doing them and us a terrible disservice. So the concept of centralized

care, or special care, I should say, has been an established fact, whether it is in infectious diseases or whether it's in heart disease or in breast cancer or whatever it may be. That concept of medicine is not unique, except in the field of HIV.

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Q: Are you aware of any specialty in dentistry for persons treating HIV patients?

A: No. And that's the rub, that dentistry has been remiss in creating a specialty in infectious diseases. They have no specialized training. OSHA requires Dr. Bragdon to supervise his employees. Well, his employees are not recertified in anything in infection and disease control
They're certified, for example, in CPR but not in infectious disease control. Therefore, how can Dr. Bragdon practice good dentistry if he himself is not required by dental purview to be an expert, which he can't because there is no specialty of infectious diseases in all the specialties of dentistry.

Q: Are you aware of any specialized facilities in Maine that provide routine dental services to HIV-positive patients?

A: No, I'm not.

Q: Is it your understanding that Dr. Bragdon referred the plaintiff in this case to a specialized center for the treatment of HIV

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patients with dental needs?

A: My only information in that regard - you'll have to excuse my lack of knowledge - is through Dr. Bragdon's deposition. And I remember a hospital where he attempted to get privileges at, but it was a very short discourse as to the availability of specialized centers. I know that Dr. Bragdon has attempted to create such a specialized center unsuccessfully, but that's all I know.

Q: Did he volunteer to serve at that facility, as far as you

know?

A: I don't know that.

Q: Any other points of disagreement you have with respect to Paragraph 7?

A: I think I've just articulated my objections to Paragraph 7.

Q: I just wanted to make sure you had a full opportunity. What are your areas of disagreement with Paragraph 8?

A: I strongly disagree with Paragraph 8 for the reasons I just articulated about Paragraph 7. That a general dentist by training, by experience, by certification, by recertification and by the

[Page 252]

ever changing kaleidoscope of change in HIV and associated opportunistic infections, in fact in emerging diseases, is not qualified to deal with this onus of responsibility.

Q: Do you think a general dentist lacks the expertise necessary to treat patients with hepatitis B?

A: Again, that's a rather difficult judgment call without knowing the condition of the patient. If the patient with hepatitis B, for example, has cancer of the liver, then that's one story. If the patient is totally asymptomatic and had hepatitis B and recovered, that's another story. If the patient is E antigen positive as a chronic carrier, that is still a third story that carries a difference - again, I really don't want to be , I hope you don't construe me as being argumentative. I'm trying to say to you that it requires medical judgment.

Q: Medical judgment including an individualized assessment of the particular patient that the dentist …

***

RANDON BRAGDON, D.M.D. INFECTIOUS DISEASE POLICY

Patients will not be treated in the office who are known to be infectious and/or contagious with a disease that is life threatning (sic) or may cause long term or permanent debility. This includes but is not limited to strep throat, hepatitis A,B,C and non A-B, HIV+/AIDS, TB, measles etc.

Patients will be treated when their attending physician determines that the patient is no longer infectious and/or contagious.

Patients of record who require emergency dental treatment and are infectious and/or contagious as specified above will be referred to an appropriate treatment setting.

This policy has been in effect since September 18, 1978.

EXCERPTED FROM THE AMERICAN DENTAL ASSOCIATION POLICY ON AIDS, HIV INFECTION AND THE PRACTICE OF DENTISTRY

PROFESSIONAL CONSIDERATIONS

The Association believes that HIV-infected individuals should be treated with compassion and dignity. Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.

A sound approach to the treatment of infectious patients requires an assessment of the patient's condition based on reasonable and informed medical judgments, given the state of medical knowledge at the time. A dentist should not refuse to treat a patient whose condition is within the dentist's current realm of competence solely because the patient is HIV infected.

Dentists should be alert to signs and symptoms of HIV infection that may be identified during the provision of dental care. Patients with histories or conditions possibly indicative of HIV infection should be referred to their physicians for diagnostic procedures, counseling and medical follow-up.

The Association believes that all HIV-infected patients should disclose their HIV status and medical history: dentists, like physicians, need to know every patient's medical history in order to make appropriate treatment decisions that are in the best interest of the patient. For the same reason, the Association also strongly supports state and federal legislation that gives an HIV-infected patient's health care providers the right to share knowledge of the patient's HIV status and current medical condition without risking a violation of state or federal antidiscrimination laws and HIV confidentiality laws. The Association further strongly supports state and federal legislation that protects a dentist from charges of discrimination

if a dentist in a sincere effort to protect a patient's health, elects to refrain from treating a patient who fails to disclose his/her HIV status and medical history or allow an HIV test to be performed.

The Association urges dentists to maintain strict confidentiality of the patient's HIV status and medical condition, except as noted above with respect to sharing of information among the patient's health care providers when allowed by state or federal law. Dentists are encouraged to have an office protocol for the confidential handling of information about an HIV-infected patient.

The Association believes that individuals with HIV infection should have access to dental treatment. Treatment considerations should provide for a judicious balance between the well-being of these patients and the protection of the health of the public as well as the dental care providers.

AMERICAN DENTAL ASSOCIATION

ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT
(With official advisory opinions revised to January, 1995)

The ethical statements which have historically been subscribed to by the dental profession have had the benefit of the patient as their primary goal. Recognition of this goal, and of the education and training of a dentist, has resulted in society affording to the profession the privilege and obligation of self-government. The Association calls upon members of the profession to be caring and fair in their contact with patients. Although the structure of society may change, the overriding obligation of the dentist will always remain the duty to provide quality care in a competent and timely manner. All members must protect and preserve the high standards of oral health care provided to the public by the profession. They must strive to improve the care delivered - through education, training, research and, most of all, adhere to a stringent code of ethics, structured to meet the needs of the patient.

Principle - Section 1

SERVICE TO THE PUBLIC AND QUALITY OF CARE

The dentist's primary professional obligation shall be service to the public. The competent and timely delivery of quality care within the bounds of the clinical circumstances presented by the patient, with due consideration being given to the needs and desires of the patient, shall be the most important aspect of that obligation.

Code of Professional Conduct

1-A PATIENT SELECTION

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex, or national origin.

Advisory Opinion

1. A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.

1-B. PATIENT RECORDS

Dentists are obligated to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon requests of a patient or another dental practitioner, dentists shall provide any information that will be beneficial for the future treatment of that patient.

Advisory Opinions

1. A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental x-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full.

2. The dominant theme in Code Section 1-B is the protection of the confidentiality of a patient's records. The statement in this section that relevant information in the records should be released to another dental practitioner assumes that the dentist requesting the information is the patient's present dentist. The former dentist should be free to provide the present dentist with relevant information from the patient's records. This may often

be required for the protection of both the patient and the present dentist. There may be circumstances where the former dentist has an ethical obligation to inform the present dentist of certain facts. Dentists should be aware, however, that the laws of the various jurisdictions in the United States are not uniform, and some confidentiality laws appear to prohibit the transfer of pertinent information, such as HIV seropositivity. Absent certain knowledge that the laws of the dentist's jurisdiction permit the forwarding of this information a dentist should obtain the patient's written permission before forwarding health records which contain information of a sensitive nature, such as HIV seropositivity, chemical dependency or sexual preference. If it is necessary for a treating dentist to consult with another dentist or physician with respect to the patient and the circumstances do not permit the patient to remain anonymous, the treating dentist should seek the permission of the patient prior to the release of data from the patient's records to the consulting practitioner. If the patient refuses, the treating dentist should then contemplate obtaining legal advice regarding the termination of the dentist patient relationship.

1-C COMMUNITY SERVICE

Since dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

Advisory Opinion

1. A dentist who becomes ill from any disease or impaired in any way shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger the patients or members of the dental staff.

1-D. EMERGENCY SERVICE

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record.

Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, ...

19.

[Randon Bragdon, D.M.D.
letterhead]

November 7, 1994

Office of the Administrator,
George Avery
Down East Community Hospital
RR1, Box 11
Machias, ME 04654

Dear Mr. Avery,

Please find enclosed my application for courtesy privileges status.

Sincerely, s/Randon Bragdon,
D.M.D.

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Check third column for requested privileges REQ

RANDON BRAGDON, DMD
DOWN EAST COMMUNITY HOSPITAL
RR1 Box 11, Machias, Maine 04654

Today's Date: 11/1/94

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

National Data Bank Requires Date of Birth: 05/02/45

Identifying Information

Last Name: Bragdon | First Name: Randon | Initial: E | Social Security No.: 005-46-6718

Residence Address:
129 Hudson Road, Bangor, Maine 04401
Telephone: (207) 942-5976

Other Address:
30 Judson Boulevard, Bangor, Maine 04401
Telephone: (207) 947-0284

Citizenship: USA | E.C.F.M.G. No/Date Issued: N/A

Medicare No. 005-46-6718

Premedical Education

College or University	Degree	Honors
University of Maine	B.A. Physics	High

Street	City	State	Zip	Date of Graduation
	Orono	Maine	04473	6-1-67

Medical Education

Medical School	Degree	Honors
Tufts School of Dental Medicine	D.M.D.	Class V.P.

Street	City	State	Zip
136 Harrison Ave.,	Boston,	Mass	02111

Date of Graduation: 6-16-78

Internship

Hospital (Full Name)
Togus Veterans Hospital

Street	City	State	Zip
VAMROC	Togus	Maine	04330

Dates
April-May 1978

Type of Internship	Specialty
Dentistry	General

Practitioners Responsible for Performance (Chief of Staff, Chairman of Departments, Others)
Dr. James Schmidt, Dental Chief (207) 623-8411

Residences, Fellowships, Preceptorships, Teaching Appointments

Facility (Full Name)
University of Maine Dental Health Programs and Clinic

Street	City	State	Zip
Lincoln Hall	Bangor	Maine	04401

Dates
1979-Present

Type
Clinic and In-Office Training

Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept. etc.)
Dawn Bearer RDH, Med.

Continuing Medical Education

(blank)

Affiliations

Present Capacity with this Hospital
Consultant and Provider Dental Services

Dates 1974-Present

Facility (Full Name)
Bangor Mental Health Institute

No. of Beds: 1200-265 Present

Street	City	State	Zip
State Street	Bangor	Maine	04401

Dates: 1979-present

Membership in Professional Societies

Are you a member of the Penobscot County Dental Association? Yes.

Do you have an application pending? No

Do you intend to apply? (blank)

If you are a present member of, or applicant to, other County, State of National Society, list names and status below.

American Dental Association, Maine Dental Association, Penobscot Valley Dental Society, Academy of General Dentistry, American Ortho Society Internation Association of Orthodontics, International Dental Health Foundation

Fellowship	(blank)
Certification	(blank)
Licensing	Medical License (Name of State and County) Maine Board of Dental Examiners Date Issued Date Expires License No. 7-1-78 12-31-95 27? Drug Enforcement Administration Renewal Date 7-31-96 License No. AB8261985
Liability Insurance	Amount of Coverage Insurance Carrier 2,000,000/3,000,000 CNA Expiration Date: 11-30-9? Policy No. (blank) Agent (Name and Full Address) Morse, Payson & Noyes Insurance, 100 Middle St., P.O. Box 406, Portland, ME 04112 Prior Carrier: St. Paul During the past 10 years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? Yes. Have you ever been denied Professional Liability Insurance? No.
Disciplinary Actions	Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide full explanation on a separate sheet.

Medical License in any state	No
Other professional registration/license	No
DEA registration	No
Academic appointment	No
Membership on any hospital medical staff	No
Clinical privileges	No
Prerogatives/rights on any medical staff	No
Other institutional affiliation or status thereat	
Professional society membership or fellowship/ Board certification	No
Professional office	No
Any other type of professional sanction	No
Have there been any felony criminal charges brought against you in the last 5 years?	No

Description of current practice	Practice Limited to General Dentistry Practicing With Whom and Nature of Affiliation Solo Practitioner

Health Status	Date of Most Recent Physical Exam 4-91 Performed by Location Paul Revere Ins. Office Significant Findings: None Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately? No. Are you currently engaged in any rehabilitation program? No.
Medical References	Dr. Charles H. Dorr, P.O. Box 373, Machias, Me 04654 Tel: (207) 255-3352 Dr. William C. Caddoo, 175 Water St., Bangor, Me 04401 Tel: (207) 667-5744 Dr. William J. Deighan, 37 Bower St., Bangor, ME 04401 Tel: (207) 945-5691
Member-ship appoint-ment and privileges desired	Special Procedures (specify) General Dentistry Privileges Desired: Dental **Delineation of Medical Privileges Desired** [blank] **Delineation of Anesthetic Privileges Desired** [blank] **Delineation of Surgical Privileges Desired** [blank] **Continuation of Delineation of Surgical Privileges Desired** [blank] **Special Surgical Procedures - provide supporting documentation** [blank] **Delineation of Gynecological Privileges Desired** [blank] **Delineation of Obstetrical Privileges Desired** [blank] **Delineation of Pediatric Privileges Desired** [blank] **Continuation of Delineation of Pediatric Privileges Desired** [blank] **Delineation of Radiological Procedures** [blank]

Delineation of Orthopedic Privileges Desired
[blank]
Continuation of Delineation of Orthopedic Privileges Desired
[blank]
Delineation of Dental (maxillofacial/oral surgery) Privileges Desired
Rehabilitation of Dental Arches
Operative restorative
Crown and bridge preparation
Prosthetic replacement of teeth
Implantation of teeth
Oral Prothesis
Congenital
Traumatic
Extractions
Single, uncomplicated
Multiple, uncomplicated
Surgical removal, impacted
Intra-Oral Surgery
Root Resections
Alveoplasty
Toris mandibularis
Simple intra-oral biopsy
Lacerations
Tumors
Cysts
Infections
Appointment Recommended
Appointment Not Recommended
Appointment Deferred
Comments
[blank]

Attachment for Answer to the Question:

"During the past ten years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?"

In sixteen years of practice there has been only one malpractice suit. On December 1, 1984 I raised a flap on the wrong side in preparation to remove an impacted maxillary third molar. I had gone over the panographic x-ray several weeks before with the label properly placed and orienting the radiograph correctly. Sometime in the interim, my receptionist reversed the label for reasons known only to herself. The result was that the radiograph was reversed when used for reference during the extraction. That patient was informed immediately, the flap replaced, and the flap raised on the other side and the impacted third molar extracted. The receptionist was fired a few weeks later for not following instructions, office policies and procedures, altering records and forging my signature. It is my belief that the receptionist incited the patient to sue. St. Paul settled the suit for $1,400.00.

There is a suit pending with the Maine Human Rights Commission (MHRC) and Gay Lesbian Advocates and Defenders (GLAD) of Boston. This suit is in regards to my long standing infectious disease policy.

CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
Washington, D.C. 20537

DEA Registration Number	Expires	This Registration Fee Paid	
AB8261985		07-31-96	$210.00

Schedules	Business Activity	Date Issued
2,2N,3,3N,4,5	Practitioner	07-

Bragdon, Randon Elvin DMD
30 Judson Blvd
Bangor, ME 04401

No. 000541

STATE OF MAINE
BOARD OF DENTAL EXAMINERS
1994-1995
REGISTRATION

This is to certify that the dentist named below has duly registered to practice dentistry for the biennial period 1994 - 1995 in accordance with Title 32, Maine Revised Statutes, 1990 Chapter 16, as amended.

Randon E. Bragdon, DMD 2732
30 Judson Blvd
Bangor ME 04401

s/Ross G. Wyman, D.D.S.
Secretary, Board of Dental Examiners

Void unless validated with
Seal of the Board

EXPIRES, DECEMBER 31, 1995 DISPLAY WITH LICENSE

Board of Dental Examiners
State House Station #143, Augusta, ME 04333
Tel: (207) 287-3333

Name: Randon Bragdon
Address: 30 Judson Blvd
Bangor, Maine 04401

Log of Continuing Education Activities for the Period
January 1, 1994 to December 31, 1995 Maine Dental Lic#2732

Category 1: CDE Activities with accredited sponsorship
At least 30 credits must be earned in this category.
The total - 40 - may be earned in this category

I certify the following to be true and correct for the period January 1, 1994 to December 31, 1995. This form must be completed, signed and returned with your completed reregistration application.

Accredited Sponsor	Location of Activity City, State	Description of Activity	Dates of Attendance	Credits
Mass Dental Soc.	Boston, MA	A.I.D.S. Panel	1-20-94	3
"	"	Arin Identifications/ Haber	1-20-94	3
"	"	Oral Lesions/ Santis	1-21-94	3
"	"	Current Concepts/Lurie	1-21-94	3
"	"	Porcelains Laminates/ Panel	1-22-94	5
"	"	Complete Dentures/ Hammer	1-22-94	3
Maine Dental Assoc.	Augusta, ME	LEAD Ledgis, Edu Awareness/ Police	2-5-94	4
American Ortho Soc.	Charlotte, No. Carolina	Straight Wire Update/Gerety	4-22-94	16
Amer. Dental Assoc.	Chicago, IL	Peers Network	9-30-94	8
Amer. Dental Assoc.	Chicago, IL	HIV, Disease Considerations for Dentistry 94	10-1-2-94	10 58 credits
Phys Res. Council of Mass	Newton, Mass	Sexuality Education and STD's of the 90's	9-17-94	6

Family Institute				

Board of Dental Examiners
State House Station #143, Augusta, ME 04333
Tel: (207) 287-3333

Name: Randon Bragdon
Address: 30 Judson Blvd
Bangor, Maine 04401

Log of Continuing Education Activities for the Period
January 1, 1992 to December 31, 1993 Maine Dental Lic#2732

Category 1: CDE Activities with accredited sponsorship
At least 30 credits for Dentists (15 for Hygienists) must be earned in this category. The total - 40 for Dentists and 20 for Hygienists - may be earned in this category.

I certify the following to be true and correct for the period January 1, 1992 to December 31, 1993. This form must be completed, signed and returned with your completed reregistration application.

Accredited Sponsor	Location of Activity City, State	Description of Activity	Dates of Attendance	Credits
AGD - Massachusetts	Boston, Mass	Infection Control	1-23-92	5
"	"	Endodontics	1-24-92	3
"	"	Endodontics	1-24-92	3
"	"	Medical Emergencies	1-25-92	3
"	"	Infection Control	1-25-92	3
ME Dental	Togus, ME	Oral Diagnosis for the G.P.	2-7-92	6
ADCO	Bangor, ME	Infection Control	3-25-92	4
MDA	Samoset, ME	General Attendance	6-19-92	5
MDA	"	OSHA Update	6-19-92	3
MDA	Samoset, ME	Oral Lesions in Patients w/HIV infection	6-20-92	1.5
MDA	Portland, ME	Risk Management	4-2-93	5
Tufts Univ	Boston, MA	Future of Dentistry	5-1-93	2
Me. Dental Assoc.	Samoset, ME	Is it ___ or is it Resin-Composite	6-20-92	1.5

Me. Dental Assoc.	Togus, ME	Pharmicology - Sam Holoyd	11-19-93	6
Penob. Medical Assoc.	Bangor, ME	Maine-Universal Health Care Plan	11-18-93	1

Account Number
0004811001

NOTICE

Your professional liability insurance is written on a "claims made" basis and provides coverage for those claims which are the result of dental incidents occurring subsequent to the prior acts date stated below and which are first made against you while this insurance is in force. Please discuss with your agent.

Policy Number From Policy Period To
DLP 0481-10-01 11/30/93 11/30/94
Coverage is Provided by: Continental Casualty Co.
Named insured and Address: National Administrator
Randon Bragdon, DMD Poe & Brown, Inc.
30 Judson Blvd P.O. Box 3268
Bangor ME 04401 Tampa, FL 33801-3268
State Administrator Number:
970-039717

Limits of Insurance		**Coverage**
$2,000,000 Each Claim		Professional Liability - Claims-Made
$3,000,000 Aggregate		
$2,000,000 Each Occurrence		General Liability - Occurrence
$2,000,000 Aggregate		Products Hazard/Completed Operations Hazard - Occurrence
$0	Each Claim	ERISA Fiduciary Liability - Claims Made

$2,725.00 Policy Premium
Printed Endorsements Attached at Policy Issuance:
G-15158-A, G-15159-A, G-15160-A, G-17739-A, G-18479-A, G-19092-A, G-19093-A, G-41500-O, G11715318, G15175A18, G16856899, C90182001.

S/Corporate Secretary
Chairman of the Board
Countersigned by/Authorized Representative
G-15155A (ED 7/91) Issue Date: 10/12/93

MORSE, PAYSON & NOYES
INSURANCE

October 5, 1994

Randon Bragdon, D.M.D.
30 Judson Boulevard
Bangor, ME 04401

Dear Dr. Bragdon:

Your Professional Protector Plan policy will be expiring on 11/30/94.

As part of the renewal process, attached is a Summary of Insurance to provide you a summary of your current coverages. Please review this summary and advise us of the renewal instructions per the attached "You Tell Us" Form.

The professional liability application is also attached. Since the premium and coverage are based on the information provided in the application, it is necessary for you to complete and return it to us.

Also attached is our invoice for the estimated renewal premium based on last year's premium. Once this year's actual renewal premium has been determined, a final adjustment will be done. Because the insurance company holds us responsible for the premium as of the effective date of coverage, payment needs to be received 10 days prior to the renewal date in order to avoid non-renewal of your policy by the insurance company.

Please return the completed renewal application and your selection form in the enclosed envelope within the next two weeks.

Sincerely,
S/Leta L. Bryant, Customer Service Representative

APPLICANT'S ACKNOWLEDGMENT

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making his application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the by-laws, rules and regulations of the medical staff of this hospital, and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession. I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff. I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff, I hereby signify my willingness to appear for the interviews in regard to my application and authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others (including past and present malpractice carriers) who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I further hereby release from liability any and all individuals and organizations who provide information to the hospital or its medical staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this

hospital or its medical staff to other hospitals, medical associations and other interested persons on request regarding any information the hospital and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and to resolving any doubts about such qualifications.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

Date: November 7, 1994 S/Randon Bragdon, D.M.D.

Exhibit 1

Randon Bragdon, D.M.D.
30 Judson Boulevard
Bangor, Maine 04401
Telephone: 947-0284

Infectious Disease Policy

Patients will not be treated in the office who are known to be infectious and/or contagious when a disease that is life threatening or may cause long term or permanent debility. This includes but is not limited to strep throat, hepatitis A, B, C and non A-B, HIV-/AIDS, TB, measles, etc.

Patients will be treated when their attending physician determines that the patient is no longer infectious and/or contagious.

Patients of record who require emergency dental treatment and are infectious and/or contagious as specified above will be referred to an appropriate treatment setting.

This policy has been in effect since September 18, 1978.

[Down East Community Hospital letterhead]

[Letter to Dr. Bragdon from Down East Hospital dated 03/31/95]

Good Morning Dr. Bragdon:

In order to further process your application for appointment to the Medical Staff of our Hospital, we are seeking some additional information, as follows:

1. Please provide further details regarding the so-called John Doe case which has been discussed in various press accounts, including sharing with us:

A. Copies of any court pleadings;

B. Copies of any correspondence to or from the Maine Human Rights Commission;

C. Copies of any documents reflecting the disposition of the matter by the Maine Human Rights Commission;

D. Further detail from you as to how this suit relates to your "longstanding disease policy" and your planned response to this litigation.

2. Please provide further details regarding the lawsuit brought in early December in U.S. District Court by Sidney Abbott, including the following:

A. Copies of any court pleadings;

B. Copies of any correspondence to or from the Maine Human Rights Commission;

C. Copies of any documents reflecting the disposition of the matter by the Maine Human Rights Commission;

D. A further statement from you as to the nature of this litigation and your planned response.

3. Please share with us the nature of your "longstanding infectious disease policy".

4. If your policy is to refuse to treat AIDS and HIV patients in your office, how do you respond to statements in the press from a spokesman for the Mine[sic] Dental Association, Frances Miliano, that the "refusal to treat (in an office) based solely on the patient's HIV-positive status is unethical" based on policy statements from the ADA?

5. Please review the enclosed statement from the ADA regarding its view of ethical duties for dentists in terms of treating HIV positive patients in the dentists' offices and indicate whether you follow this view, and if not, why not.

6. Are you under any review by the State Board which licenses Dentists?

7. Are you still a member in good standing of the Maine Dental Association or under any review by that body?

8. Is it your intention to treat patients at our Hospital who might otherwise be treated at your or another dentist's office, and if so, is this cost-effective treatment for these patients?

9. Please provide any other detail you would care to share with this Hospital regarding your policy, these lawsuits, and the controversy surrounding the matter.

The Hospital's interest is in reviewing the nature of care you provide, or decline to provide, against applicable ethical and legal standards governing your profession. It is further interested in evaluating whether it is cost-effective to treat patients in a hospital setting who might otherwise be treated in a dentist's office.

We look forward to your response to each of the

preceding questions in order to evaluate your application. We will not deem your application complete until we have these materials.

Sincerely, /s/ George Avery, FACHE, Administrator
pc: F. James Whalen, M.D., Chairman, Credentials Committee

[Down East Community Hospital letterhead]

April 25, 1995

Randon E. Bragdon, D.M.D.
30 Judson Boulevard
Bangor, Maine 04401

Good Morning Dr. Bragdon:

It is my understanding you recently spoke with my secretary, Elin Bennett, to inquire regarding the status of your application, and to request that it be moved forward if possible.

Please understand that this Hospital shares your interest in addressing the issues raised by your pending application for limited privileges. In this regard, the Hospital must review carefully the issues raised in my letter of March 31, 1995, in light of the determination of the Maine Human Rights Commission at its February 13, 1995 meeting that there were "reasonable grounds" for finding against you with respect to compliance with the Maine Human Rights Act. One of the specific bases referenced in its investigator's report was your alleged deviation from pertinent principles of ethics and the Code of Professional Conduct of the American Dental Association.

These issues are pertinent to the Hospital's consideration, among other reasons, as a consequence of its own medical staff by-laws. Article III, Section 2(b) states in pertinent part that:

> Acceptance of membership on the medical staff shall Constitute the staff member's agreement that he will strictly abide by . . .the Code of Ethics of the American Dental Association. . . .

The Hospital is further legitimately concerned with whether your actions comply with applicable state and federal laws, and contribute to the cost effective treatment of its patients.

For the Hospital to evaluate these issues, it is essential that you provide us with responses to the questions we have raised. With this information we may be able to process your application, or we may determine that the Hospital should defer action or is not able to make determination until the Federal Court litigation is resolved. We are willing to consider the information you provide further and make such a determination at that point.

I also wish to advise that I will be leaving the Hospital's staff as of April 28, 1995. Following my departure, Lois Macias, Director of Support Services, will be handling these issues. Also, the Hospital has arranged for counsel to guide us in this matter. Should your attorney have any questions about the Hospital's position we will provide identity information.

I trust you will have a better understanding of the basis for the Hospital's position and its concerns. We look forward to addressing the issues raised by your application against this background and hope this information is helpful.

Sincerely, s/George Avery, FACHE, Administrator
p.c. F. James Whelan, M.D., Chairman Credentials Committee
Lois Macias, Director, Support Services

SEPTEMBER 1, 1995 DEPOSITION OF ROBERT VEROSLOFF, M.D.

[Caption omitted in printing]

[Page 1]

Taken before Cheryl C. Pieske, Registered Merit Reporter and Notary Public, in and for the State of Maine, on September 1, 1995, at the Down East Community Hospital, Machias, Maine, commencing at 7:45 a.m., pursuant to notice given.

Appearances:
For the Plaintiff:
(Via Telephone) Bennett H. Klein, Esq.
For the Defendant: John W. McCarthy, Esq.
For Down East
Community Hospital: Penny St. Louis, Esq.

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(The deposition of Robert Verosloff was taken at the Down East Community Hospital, Machias, Maine, on September 1, 1995. Present for the deposition in Machias, Maine, were Penny St. Louis, Esq.; John W. McCarthy, Esq.; Cheryl C. Pieske, RMR, and Randon Bragdon, D.M.D. Present via telephone were Bennett Klein, Esq. and Daniel Jackson.)

(Deponent administered oath by the reporter.)
ROBERT VEROSLOFF, being duly sworn, on his oath, deposes and says as follows:

EXAMINATION

BY MR. KLEIN: (Via telephone).

Q. Could you state your full name for the record?
A. Robert Leland Verosloff.
Q. Are you on the staff of the Down East Community Hospital?
A. Yes.
Q. And what is your position at the Down East Community Hospital?
A. Physician. Also on, I guess for this, on the board of the – the head of the infectious control.
Q. And can you tell me what your responsibilities are as the head of infectious control?

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A. Well, to oversee the meetings, to make sure the the [sic] policies are implemented and that the controls are there.
Q. Okay. And by controls, are you referring to any hospital policies for the control of infectious diseases in the hospital setting?
A. Yes.
Q. What are a of medicine do you practice in?
A. Internal medicine.
Q. How long have you been the head of infectious control at the hospital?
A. Two years.
Q. And as head of infectious control, are you familiar with the infection control methods and procedures used at

the hospital?
A. Yes.
Q. Okay. And that would include the infection control methods or procedures used in surgical operatories or other patient treatment areas?
A. That would include the whole hospital.
Q. Okay. Does any surgical operatory at Down East Community Hospital have ultraviolet lights?
A. No.
Q. Hello?
A. No.

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Q. I'm sorry. Did you hear me?
A. Yes. I said no.
Q. Oh, okay. Just because I didn't hear your answer, I just want to ask the court reporter if you could just read back the question and answer so I know that we got it because my phone was a little bit off.
(Last question and answer read by reporter.)

BY MR. KLEIN:

Q. Does any surgical operatory or is any surgical operatory at the Down East Community Hospital constructed with negative air pressure?
A. No. No.
Q. Okay. Dr. Verosloff, are there different types of operating rooms at the hospital?
MS. ST. LOUIS: Ben, what do you mean by that? Could you be more specific?
MR. KLEIN: Sure.
Q. Could you describe to me the different types of rooms that patients would be treated in for surgical procedures?
A. I don't think I could do that. I don't deal with surgery well enough to –
Q. Okay. Do you know how many different patient surgical rooms there are at the hospital?

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A. Do you mean operating rooms or do you mean rooms

on the floor for patients after the surgery?
Q. Well, let's start with operating rooms.
A.. Operating rooms, I don't know.
Q. Okay.
A. I believe that they are all the same though.
Q. Okay. And when you say all the same, are there – would those include both rooms for outpatient day surgery as well as patients who may be staying in the hospital?
A. We don't have any special facilities for outpatients.
Q. Okay. Now, with respect to the operating rooms, have you ever seen them?
A. I have been in them but just as a visitor.
Q. Not as a surgeon?
A. Not as a surgeon.
Q. Okay. And based on your observations of the operating rooms, do they have tables for the patients that are actually fixed in place?
A. Yes.
Q. Okay. So those tables where the patients lie for their surgery cannot be removed, is that correct?
A. As far as I know, yes.
Q. Are there other pieces of equipment such as

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anesthesia units in the operating rooms which, based on your observations, are fixed in place?
A. Not that I know of.
Q. Is there any operating room at the Down East Community Hospital which currently has in it a dental chair and dental delivery unit?
A. Not that I know of.
Q. Do you know if the hospital – strike that. Well, do you know if the hospital has a dental chair and dental delivery unit?
A. No, I don't.
Q. I'm sorry, if there was an answer, I didn't catch it.
A. No, I don't.
Q. Okay. With respect to the operating rooms at the Down East Community Hospital, do you happen to know what the number of air exchanges per hour is in

those rooms?
A. No, I don't have that information either.
MR. KLEIN: Now, Penny?
MS. ST. LOUISE: Yes.
MR. KLEIN: I just want to mark as an exhibit the bill which was provided to me yesterday.
MS. ST. LOUISE: Okay.

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MR. KLEIN: Do you happen to have that?
MS. ST. LOUIS: Yes, we do. It has been marked as Exhibit Number 1.
MR. KLEIN: Okay.
Q. Dr. Verosloff, I would like you, if you could, to take a look at Exhibit 1, which I will state for the record has been provided to me by Attorney St. Louis as a representative bill for dental services which have in the past been provided at Down East. And if I could call your attention to the top of the second page, do you see the notation OR Minor?
A. Yes.
Q. Okay. And what does that refer to, if you know?
A. I don't know. I would only be guessing.
Q. Okay. Can we go off the record for just one second?
A. Okay.
MR. KLEIN: Are we off the record?
MS. ST. LOUIS: Yes.
(Off the record colloquy).
MR. McCARTHY: I don't want to be off the record for these conversations, if nobody minds.
MS. ST. LOUIS: Okay.

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believe that they are mostly in Africa. We are not real concerned at this point.
Q. Do you know anything about the different infection rates of the different sub types of HIV 1?
A. No, I don't.
Q. Are you – is Down East Community Hospital equipped

to deal with active infective tuberculosis?

A. No, not really. We have been very, as I said before, we have been very lucky and not had to deal with it.

Q. If you do have a case of multi-drug resistant TB, do you refer those patients some place else for care?

A. As of yet we've never had one, but we would send them to Eastern Maine.

Q. Why?

A. One, because we don't have the rooms for it. We don't have the special precautions for it. Two, we are just not – we don't see enough of it to be able to deal with it.

Q. Do you have the engineering controls recommended by the CDC for treatment of TB patients?

A. We try to go by the CDC guidelines. We do not

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have all of the controls in place.

MR. McCARTHY: Just give me a second here.

(Brief pause).

BY MR. McCARTHY:

Q. Does the hospital ever utilize precautions above the bare minimum set by the CDC with respect to infection control?

A. Well, not usually but, you know, we went ahead and used a hepafilter before that was made a CDC requirement, and now it looks like it's not going to be. So in that respect, yes, we are above the CDC, but in most respects, no, we are not. Because we see so little TB, we see so little HIV, we just haven't needed to do it and really haven't.

Q. Are you familiar with the guidelines set by the CDC for the prevention of nosocomial hospital infections?

A. Well, what we do is we have used – go basically by the universal precautions.

Q. Are you familiar with the body substance isolation guidelines?

A. We have protocol for that, and it is used when we feel appropriate. However, a lot of – most of

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the time when we end up with a patient in that sort of condition, they, too, do get sent to the Eastern Maine Medical Center.

Q. What is nosocomial hospital infection?

A. That's one that is transmitted in the hospital usually from patient to patient or doctor to patient, whatever, where it's usually a more virulent, a more – a worse bug, one that is harder to treat, that is more resistant to antibiotics.

Q. Does the hospital always refer such patients because its mandatory, or does the hospital refer such patients to another setting because they think it's more appropriate and just good judgment?

MR. KLEIN: Object to the form. And what such patients are you referring to?

BY MR. McCARTHY:

Q. I don't have to answer his questions. He just makes comments. You still answer.

A. All right, We don't have infectious disease specialists here. So that's one advantage of sending them down. We don't have the isolation rooms yet. We hope to with the special care unit. We don't have that yet. Some hospitals

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makeshift – make negative pressure rooms by putting a fan in the window and turning it backwards. We haven't really tried anything like that. We hope to be able to have a sufficient room with the special care unit.

Q. What is the purpose of negative air pressure in an operating room?

A. Because you want to blow the pathogens, the organisms outside and not contaminate the people inside, the people around. Basically it's for the protection of people.

Q. If any HIV positive patient comes to Down East

Community Hospital for surgery, do you refer that patient to Eastern Maine or some other facility for the reasons you have been describing?

MR. KLEIN: Object to the form.

A. I'm not sure it has happened enough to really tell you. It's like the amount of TB cases, I think we had one over the last two years, and that person was sent to Eastern Maine; one, because you have the pulmonologists there who can do bronchoscopy and get better samples; two, you have the pathologists and the infectious disease people down there. Most of our – I guess our thinking is we feel like a rural hospital, and we ....

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DEFENDANT'S MOTION FOR AN ENLARGEMENT OF TIME WITHIN WHICH TO FILE HIS OPPOSITION TO PLAINTIFF'S MOTION TO EXCLUDE HIS EXPERT TESTIMONY DATED 09/27/95

(Caption omitted in printing)

The defendant, Randon Bragdon, D.M.D., hereby moves for an enlargement of time within which to file his response to plaintiff's motion to exclude him as an expert witness. Dr. Bragdon requests that the time for filing his opposition to that motion be enlarged until ten days following the Court's ruling on the parties' cross motions for summary judgment. This request is consistent with the Court's August 31, 1995, Report of Final Pretrial Conference and Order in which the Court orders that "all filings [including, under Section 3, "objections to the qualifications as to any expert witness], except the consolidated witness list and voir dire, will be due **ten** days following the court's ruling." Report of Final Pretrial Conference and Order at 8. The grounds for Dr. Bragdon's motion are as follows:

1. Dr. Bragdon is not relying upon his testimony as an expert witness on infection control practices or infectious diseases at the summary judgment stage. If, at summary judgment, Dr. Bragdon were submitting an affidavit or relying upon his deposition testimony as an expert on the transmission of infectious diseases at the summary judgment stage, Ms. Abbott is in no way prejudiced by the Court granting Dr. Bragdon's motion for an enlargement of time within which to respond to her motion to exclude him as an expert witness.

2. Dr. Bragdon has the burden of responding within ten days to lengthy motions for summary judgment and legal memoranda (approximately 90 pages) submitted by the United States, Ms. Abbott, and the Maine Human Rights Commission. The additional burden of having to respond to an issue that is irrelevant at this stage in the litigation would significantly impair his ability to respond to the other, important motions. Indeed, if this motion for an enlargement

of time is denied, Dr. Bragdon requests in the alternative an enlargement of time until October 20, 1995, within which to respond to all of the motions filed by the United States, the Maine Human Rights Commission, and Ms. Abbott.

3. Counsel for Ms. Abbott indicate that they oppose Dr. Bragdon's motion for additional time within which to respond to their motion to exclude Dr. Bragdon as an expert witness; but they do not oppose a motion for an enlargement of time within which to respond to all the motions. Dr. Bragdon believes this position is illogical, and prefers to respond to the summary judgment motions as scheduled, and the motion to exclude Dr. Bragdon ten days after the Court's ruling on the summary judgment motions.

WHEREFORE, Dr. Bragdon respectfully requests an enlargement of time until ten days after the Court rules on the parties' cross motions for summary judgment to respond to Ms. Abbott's motion to exclude him as an expert witness on infectious diseases at trial. In the alternative, Dr. Bragdon seeks an enlargement of time until October 20, 1995, within which to respond to the motions filed by Ms. Abbott, the Maine Human Rights Commission, and the United States.

Dated: September 27, 1995

s/ John W. McCarthy,
Esq.

s/Brent A. Singer, Esq.
Rudman & Winchell
Attorneys for Defendant

SUPLEMENTAL AFFIDAVIT OF JOHN A. MOLINARI, PH.D. DATED 10/03/95

(Caption omitted in printing)

I, John A. Molinari, Ph.D., state as follows:

1. I hold a Ph.D. in microbiology from the University of Pittsburgh and am currently a Professor and the Chairman of the Department of Biomedical Sciences at the University of Detroit Mercy School of Dentistry. My career has been focused on studying and teaching about the prevention of transmission of infectious diseases in the dental setting. (Footnote 1: I am co-author of the textbook Practical Infection Control in Dentistry, Lea & Febiger (1991). I have been a consultant to the American Dental Association Council on Dental Therapeutics and the United States Centers for Disease Control and Prevention (CDC) on infection control in dentistry, the development of universal precautions, and the prevention of transmission of bloodborne pathogens including HIV in health care settings. I have also served as President of the Society for Infection Control in Dentistry and the Microbiology and Immunology Group of the American Association for Dental Research. I am on the Editorial Board of the Journal of the American Dental Association and have written and lectured widely on infection control in dentistry and the epidemiology and transmission of HIV. (end of Footnote 1).

2. I have read Defendant Randon Bragdon, D.M.D.'s Rule 19 Statement of Undisputed Material Facts and Defendant's Motion for Summary Judgment. I submit this Supplemental Affidavit to rebut the incomplete and misleading statements in those documents and also to point out that Defendant Bragdon's facts do not support his conclusions about the transmission of HIV in dentistry.

3. Dr. Bragdon cites my testimony for his claim that the risk of transmission of HIV from a patient to a dentist is much greater than the risk of transmission of HIV from dentist to patient. This statement is misleading and does not reflect the full substance of my opinion.

The risk of transmission from dental health care worker to patient and the risk from patient to a dental health care worker are both infinitesimally small. However, if both of these infinitesimally small risks are placed side-by-side, the relative or comparative risk is generally greater for the dental health care worker. But that does not change my opinion that both such risks are so small as to be immeasurable.

4. In his Statement of Undisputed Facts, Defendant Bragdon states that there is "a risk" of transmission of HIV from patient-to-dentist. Defendant Bragdon's apparent basis for this statement is that a dentist can be "exposed" to a patient's blood. (Statement of Facts: Numbers 1, 5, 11, 12, 13). However, these statements do not indicate in any way that such a transmission has ever occurred nor do they indicate the probability of such a transmission occurring in the future.

5. In microbiology and infectious diseases, there is a critical distinction between "exposure" and actual "transmission" of infection. Exposure to blood is not synonymous with infection or the actual transmission of HIV. HIV is a virus of low infectivity which generally cannot be occupationally transmitted without the injection of a large volume of blood into the tissues of a health care worker. Even in the event of an injection of a large volume of HIV-infected blood, transmission rarely occurs due to the low infectivity rate of HIV. In dentistry, any exposure to a patient's blood occurs in such small volumes which have not been shown to result in the transmission of HIV.

6. Because of the low infectivity of HIV, combined with the effectiveness of standard infection control procedures, there has never been a known case of HIV transmission from patient-to-dentist. Thus, while Dr. Bragdon states that there is "a risk" of HIV transmission from patient-to-dentist, that risk has never been demonstrated to have actually occurred. The current data indicate that the risk of such an occurrence in the future is infinitesimally small to negligible.

7. In addition, it is important to keep in mind that the implementation of the standard universal precautions

significantly reduces exposure to a patient's blood in the first place. The recommended universal precautions include barriers such as gloves, gowns, masks and protective eyewear to prevent contact with a patient's blood. The universal precautions also include techniques for the safe handling of needles and sharp instruments which reduce accidental percutaneous injuries. Thus, the universal precautions significantly reduce the already negligible chance of transmission of HIV from patient to dental health care worker.

8. There is no evidence that blood or bloody saliva has ever transmitted HIV in dentistry through the nose, eyes or mouth when a dentist is utilizing barrier protections such as gloves, gowns, masks and protective eyewear. There is no evidence that blood goes up a dentist's nose or into a dentist's mouth during the practice of general dentistry.

9. Moreover, if a dental health care worker has a cut, abrasion or dermatitis on the skin, any risk of HIV transmission can be eliminated by covering the area. For example, a face shield can be worn instead of or in addition to a mask or a small cut can be covered with a band aid. If a cut, scratch or dermatitis is so small as to not be noticed by a health care worker, then a sufficiently large enough volume of blood to transmit HIV could not pass through the skin. A dental health care worker is able to cover all body surfaces which can be exposed to blood splatters during the practice of general dentistry.

10. Dr. Bragdon states that there is a risk of HIV transmission through a needlestick occurring during the injection of a local anesthetic. This has never been demonstrated to have resulted in HIV transmission during dentistry. This is due, at least in part, to the extremely small amount of blood which a dentist would be exposed to from such an accident. The needle used to inject local anesthetic has a very small opening at its tip which will not hold a large volume of blood (compared, for example, to a needle used to draw a blood sample from a patient). In addition, the anesthetic is never injected near an artery or other significant blood source. Thus, if a dentist is accidentally stuck with a needle, the dentist will be exposed only to a very small amount

of the patient's blood. The small volume of blood is further reduced because some of it is wiped off when the needle passes through the latex glove.

11. Dr. Bragdon can virtually eliminate the occurrence of an accidental needlestick by following the currently recommended procedure for the injection of a local anesthetic. According to Dr. Bragdon's Statement of Facts, his practice is to place his fingers in the patient's mouth next to the needle while he injects the anesthetic. The currently recommended procedure involves removing one's hand from the injection site, retracting the cheek with a mirror, and injecting the anesthetic with the other hand. This method virtually eliminates any risk that a dentist will be stuck with a needle during the injection of a local anesthetic. Other types of injuries in dentistry with solid or sharp instruments are not inevitable, buy may occur. However, these solid instruments transfer even less blood than needles used for local anesthesia and have never been shown to transmit a virus of such low infectivity as HIV.

12. It is true that three to four percent of persons with AIDS have not disclosed identifiable behavioral risk factors for HIV infection. However, this statistic does not at all illuminate[sic] the probability of HIV transmission from patient to dental health care worker. There is no scientific or epidemiological basis to make the leap that any of these individuals occupationally contracted HIV. In addition, there is no evidence as to how many, if any, such persons are dental health care workers.

13. HIV is not an airborne pathogen and there is no evidence that HIV can be transmitted through the air. A special respirator mask which filters airborne pathogens is not helpful in reducing the transmission of HIV.

14. There is no evidence of patient-to-patient transmission of HIV in dentistry. If a dentist follows CDC recommendations to heat sterilize instruments between patients, as I am informed that Dr. Bragdon does, there is no risk of HIV transmission from patient-to-patient in dentistry. Heat sterilization, by definition, kills all microorganisms on

dental instruments, including HIV.

Dr. Bragdon cites as Exhibit 7 of his Motion an article in Nature magazine to support his statement that HIV can be transmitted from one patient to another patient in the dental office. Dr. Bragdon's use of the Nature article is inaccurate and grossly misleading. The article unequivocally states:

> Adherence to CDC heat-sterilization standards virtually eliminates risks of blood-borne disease transmission by reused dental devices. (p. 956).

The part of the article which Dr. Bragdon quotes in his Motion (p. 23) indicates only that the researcher isolated HIV entrapped in instruments which had not been heat sterilized, but which instead had been soaked in a disinfectant.

15. There is no evidence that HIV can be transmitted by bloody saliva that is retracted into the dental water unit lines. The standard procedure in dentistry is to flush the water lines between patient uses. No one has ever recovered live HIV in flushed dental water unit lines nor is there any evidence that HIV can survive in water. In addition, it is recommended that dentists use anti-retraction valves which prevent water or bloody saliva in a patient's mouth from being retracted into the water lines.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Dated: 10-3-95 /s/ John A. Molinari, Ph.D.

SUPPLEMENTAL AFFIDAVIT OF DONALD E. CRAVEN, M.D. (CAPTION OMITTED IN PRINTING)

I, Donald E. Craven, M.D., state as follows:

1. The health care profession necessarily and unavoidably involves exposure to patients with infectious diseases. Therefore, when a person chooses to work in health care, including medicine and dentistry, he or she accepts the reality of exposure to infectious diseases.

2. Because many patients with infectious diseases, including HIV, may be asymptomatic and have not been identified, a health care worker cannot avoid exposure to infectious microorganisms, including viruses and bacteria. Exposure to patients with such infectious diseases occurs in every health care setting – including a hospital and a private medical or dental office.

3. In his Motion at pp. 24-25, Dr. Bragdon misquotes my testimony. My opinion that a health care worker should treat patients with HIV is premised on my opinion that the risk of infection to the health care worker is infinitesimally small, less than the risk of death involved in driving a car or being struck by lightning. Moreover, since many people with infectious diseases are asymptomatic and are not detected, health care workers face some risk in the performance of their professional obligations, even though it is negligible.

4. A woman with HIV disease has a significant risk of transmitting HIV to a newborn. HIV-positivity substantially affects and limits an HIV-positive woman's decision and ability to procreate safely.

5. During my deposition in this case, I was not asked how HIV-positivity affects or limits procreation. If I had been asked that question, I would have provided my opinion as stated in paragraph four above.

I DECLARE UNDER PENALTY OF PERJURY

THAT THE FOREGOING IS TRUE AND CORRECT.

Dated: 10/4/95 s/Donald E. Craven, M.D.

DECLARATION OF DONALD WAYNE MARIANOS, D.D.S., M.P.H. DATED 10/06/95

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Donald Wayne Marianos, D.D.S., M.P.H. declare that:

I have read Defendant Bragdon, D.M.D.'s Rule 19 Statement of Undisputed Material Facts and Defendant's Motion for summary Judgment. Based upon my education, experience and expertise I offer the following opinions in this case:

1. I am the Director of the Division of Oral Health at the Centers for Disease Control and Prevention ("CDC"). It is the position of the CDC that when universal precautions are used, persons with HIV or AIDS or other blood-borne pathogens can be safely treated in private dental offices.

2. Dr. Bragdon uses the example of the administration of a local anesthetic as a means by which he could acquire HIV occupationally. The risk of exposure by this method can be reduced by using instruments instead of fingers to retract tissue or guide anesthetic needles during injections. In a recent CDC observational study of general dentistry and oral surgery residents in New York City, no injuries were reported during the administration of over 16,000 anesthetic injections by residents who were taught this preventive technique (Cleveland, JADA 1995). In addition, self-sheathing anesthetic syringes are now available to prevent needlestick injuries during or after anesthetic injections.

3. No scientific data is available to support the hypotheses that aerosolized particles containing infective HIV may be produced in dental or medical settings or that HIV may be transmitted by aerosols by the respiratory route (Short 1993). Thus, use of a particulate respirator is completely unjustifiable to prevent transmission of HIV in any health-care setting, including dental settings.

4. The risk of acquiring HIV following a mucous membrane exposure (0.09%) or skin exposure (<0.04%) to HIV infected blood is much less than the risk following a percutaneous exposure (0.3%). These risk estimates are for contacts with blood and would likely be much lower for blood contaminated saliva. Use of gloves, masks (standard surgical) and eyeglasses, or faceshields, as required by universal precautions, can easily protect the dental worker from skin and mucous membrane exposures to blood or saliva contaminated with blood. Additional precautions for dentistry include the use of rubber dams, high-speed suction, and proper patient positioning. CDC guidelines also recommend that dental workers with open sores, oozing dermatitis, or other similar lesions avoid patient contact until the skin has healed.

5. Studies of injuries among dentists indicate that the number of sharps injuries reported by dentists have decreased from about 12 injuries per year in 1987 to the current rate of 3-4 injuries per year (Cleveland, Infect Control Hosp Epidemiol 1995).

6. Studies also have found that injury rates among dental workers are probably less than among general surgical personnel. Data from CDC's observational study among general dentistry and oral surgery residents found that dental residents experienced about 2 injuries per 1000 hours of observation, a much lower rate of percutaneous injuries than general surgery personnel who, in another CDC study, experienced 34 injuries per 1000 hours of observation.

7. Infection control recommendations to prevent the retraction of patient material into dental unit water lines have been addressed in CDC guidelines since 1986. These recommendations should be followed in all health-care settings where dental treatment is provided (including private dental offices and hospital dental settings).

8. The CDC has established a hierarchy of exposure categories (or "identifiable risk factors") for HIV. The hierarchy of exposures include: men who have sex with men; injecting drug use; men who have sex with men and inject

drugs; heterosexual contact (with infected individuals); hemophilia/coagulation disorder or receipt of blood transfusion, blood components, or tissue.

9. "No risk reported or identified" cases involve persons with no reported history of exposure through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was unavailable and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

10. At any given time, there will be a number of cases with no identified risk. Among those, the majority will fall into the category described above as "currently under investigation." The follow-up investigation for a majority of these cases will reveal an identified risk factor (within the hierarchy of risk factors), and the case will be appropriately reclassified.

11. The vast majority of health care workers with AIDS have reported nonoccupational risk factors for HIV infection. Studies have revealed that, since 1987, a higher proportion of health care workers compared with other persons with AIDS, 6% vs. 3%, have been classified in the undetermined risk category. However, it is likely that a number of these health care workers had nonoccupational risk factors that they did not report or recognize (e.g., sexual contact with a partner suspected or known to be infected).

12. There is no scientific evidence whatsoever to support Dr. Bragdon's statement at pp. 13-14 of his brief, that transmissions of HIV by "a drop of blood going up the nose of the dentist, or a drop of blood landing on a cut or scratch on his body of which he was aware. . .may be occurring with "alarming frequency," but have not been documented. If in fact, transmissions of HIV from infected patients to dentists

were occurring with "alarming frequency", one would expect a high rate of previously undetected HIV infection among the over 6,000 dentists who have participated in seroprevalence studies conducted at annual meetings of the American Dental Association. However, these studies continue to indicate very low HIV-seroprevalence (Gruninger 1991, Siew 1994).

13. The CDC identifies "possible" cases of occupational transmission in the health care setting as those in which "health care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids. . .but HIV seroconversion specifically resulting from an occupational exposure was not documented."

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

Executed on
October 6, 1995

s/Dr. Donald Wayne Marianos
Dr. Donald Wayne Marianos
Director, Division of Oral Health

Centers

for Disease Control and Prevention
NCPS/DOH
1600 Clifton Road, N.E.
Mail Stop F-10
Atlanta, Georgia 30333

SUPPLEMENTAL DECLARATION OF DEBORAH GREENSPAN, BDS, DSc, ScD(hc), FDS, RCSFd(Hon) DATED 10/5/95

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Deborah Greenspan, BDS, DSc, ScD(hc), FDS RCSEd(hon) declare that:

I have read Defendant's Motion for Summary Judgment in his above-referenced matter. Based on my education, experience and expertise I offer the following additional opinions in this case:

1. I am currently Clinical Professor of Oral Medicine at the University of California at San Francisco and am also Chair of the Compliance Committee on Infection Control at the UCSF School of Dentistry. I have treated over one thousand patients who are HIV-positive. In addition, I have supervised many dental students and residents who routinely treat HIV-positive patients in the dental clinic and use the same infection control procedures as can and should be used in a private dental office. It is my opinion that HIV-positive patients may be safely treated in a private dental office when universal precautions are used.

2. The proper way to reduce the transmission of infectious diseases is not to refuse to treat those who actually acknowledge harboring such diseases, but rather, to treat all persons as if they are potentially infectious. Many persons who are infectious for HIV, Hepatitis B, and other bloodborne pathogens do not know that they are infected, and many of those who do know their infectious status may choose not to inform their health care providers of this fact.

3. If a health care worker such as Dr. Bragdon believes that he is eliminating the risk of occupationally acquiring an infectious disease by refusing to treat those who acknowledge their infectious status, he may actually be creating a more risky environment for himself, his staff, and his other patients. By believing he has eliminated a risk,

where, in actuality, he has not, he may become less stringent in his practice of infection control.. If, on the other hand, Dr. Bragdon treats all patients as potentially infectious, regardless of what they know or choose to disclose, then Dr. Bragdon will use the highest infection control procedures at all times, and will be operating in an environment in which the risk of transmission of HIV and other bloodborne pathogens is almost negligible.

4. Those of us who work in health care, and in dentistry in particular, do not expect to work in a risk free environment. Just as a firefighter expects to be exposed to fires, health care workers expect to be exposed to people who are sick, including those who harbor infectious diseases.

5. At the time Dr. Bragdon started practicing, it was common knowledge that Hepatitis B posed a significant occupational risk to dental health care workers. Hepatitis B is a highly infectious virus. Approximately 200 health care workers die from Hepatitis B infection on a yearly basis, and countless more suffer permanent and debilitating Hepatitis B-related conditions.

6. As a dentist, I believe that the ethical duties of our profession oblige us to help those in need, including those with HIV/AIDS. I believe that it is unethical to deny care to a patient because you are afraid of treating that patient, especially, where, as here, one's fears are not grounded in science.

7. In his affidavit, Dr. Bragdon describes the method by which he administers a local anesthetic before filling a cavity on a back, lower tooth, such as Mr. Abbott's. Current recommendations include retracting (pulling back the lip and cheek) with a mirror rather than one's fingers, so that an accidental injury of the type described by Dr. Bragdon could not happen. This method is easy to perform and greatly reduces the chance of accidental injury.

8. In his brief, Dr. Bragdon alleges that the filling of a cavity creates an "obvious" risk of transmission of HIV from patient to dentist, and that intraoral injuries (i.e., those

occurring inside the patient's mouth) are "inevitable" in the dental setting. These allegations are not supported by current science. Rather, recent studies demonstrate that, on average, dentists only incur three to four percutaneous injuries per year, of which the majority occur outside the patient's mouth. Moreover, in approximately 99.7% of the cases in which a health care worker suffers a percutaneous injury from a needlestick that is actually contaminated with HIV-infected blood, the health care worker will not acquire HIV. The chance of acquiring HIV from any other type of sharps injury is significantly less. Most importantly, there has never been a documented case of HIV transmission from patient to dental health care worker.

9. In his brief, Dr. Bragdon describes hypothetical means by which a dentist or his assistant could contract HIV while treating a patient. These are all based on conjecture and speculation, with no support in science. There is no evidence whatsoever that HIV can be transmitted via aerosolization. Similarly, there is no evidence that HIV can be transmitted through the nose or the mouth or through defects in the dental mask. If a dental health care worker has dermatitis on an ear, or a scratch or an abrasion that is not already covered by her gloves, gown, and protective face covering, the dental health care worker should cover the exposed skin (e.g., with a bandaid) before treating any patient. In addition, regardless of whether a dental health care worker's gloves are visibly contaminated with blood, he or she must remove those gloves before touching any part of his or her body. If the cut or abrasion is so insignificant as to not be noticed by the dental health care worker, then it is almost impossible for a sufficient amount of HIV-contaminated blood to enter the dental health care worker's bloodstream via the cut. There must be a significant cut or scratch and a significant amount of blood for the dental health care worker to acquire HIV occupationally.

10. HIV is not an airborne pathogen. No public health, scientific, medical, or dental organization has ever recommended that a dentist wear a respirator when treating an HIV-positive patient.

I hereby declare under penalty of perjury that the

foregoing information is true to the best of my knowledge and belief.

Executed on
October 5, 1995

s/Deborah Greenspan
Dr. Deborah Greenspan
University of California at
San Francisco
School of Dentistry
513 Parnasus Avenue, Box 0422, S-612
San Francisco, CA 94143

DECLARATION OF DONALD WAYNE MARIANOS D.D.S., M.P.H. DATED 10/18/95

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I, Donald Wayne Marianos, D.D.S., M.P.H., declare that:

I have read Defendant's Memorandum of Law in Opposition to Plaintiff's Motion for Summary Judgment, and the Second Declaration of Sanford F. Kuvin, M.D. Based upon my education, experience and expertise I offer the following additional opinions in this case:

1. While statistical modeling, such as that employed by Dr. Kuvin, may be useful in estimating orders of magnitude of the risk of HIV transmission from an HIV-infected patient to dentist, these models are based on a multitude of assumptions. Estimates derived from theoretical modeling can only be as accurate as the sum of the modol's individual elements.

2. Dr. Kuvin uses an estimate of 1.5 needlestick injuries per 100 injections given by dentists. In a more recent study (Cleveland, JADA 1995) in which dentists were observed for 6 months, zero injuries were recorded during over 16,000 injections. Siew's prospective "Diary" study (JADA 1995) found an annualized mean injury rate of about one needlestick every two years.

3. Dr. Kuvin uses the estimate that 3 out of 1000 accidental needlesticks from HIV-contaminated needles will result in occupational acquisition of HIV. While this is an accurate statistic, it represents the risk to all health care workers generally, not dentists specifically. The risk of HIV transmission following a percutaneous exposure to HIV infected blood is likely to depend on several factors, including the size of inoculum (i.e., the amount of blood injected). Because the size of anesthetic needles used in dentistry is much smaller than that used in most medical settings, the

majority of needlesticks among dental workers will involve smaller, rather than larger amounts of HIV infected blood. It is the position of the CDC that the risk of acquiring HIV occupationally from a needlestick in the dental setting is so low that it cannot be accurately quantified.

4. Dr. Kuvin also uses the assumption that 1 out of 3 needlestick injuries to dentists results in parenteral exposure to patient blood. I am unaware of any study supporting this assumption.

5. Dr. Kuvin is incorrect when he states "1/3 of all reported exposures for dental workers have HIV, and no other identifiable risk factors except for occupational exposures." Dr. Kuvin has confused CDC's prospective needlestick study (described in the Gooch article attached to Dr. Kuvin's affidavit) and CDC's surveillance system for HIV/AIDS. The nineteen dental workers described in the Gooch article were voluntarily enrolled in a national prospective study of health care workers exposed to HIV infected blood. To our knowledge, none of these exposures resulted in HIV transmission to an enrolled dental worker.

This study is completely separate from the CDC's ongoing surveillance system, in which six dental workers with AIDS have been identified as having no identifiable risk factors other than percutaneous or mucocutaneous exposure to blood. As noted in my previous affidavit, it is likely that a number of health care workers identified as having no identifiable risk factors actually had nonoccupational risk factors that either they or their proxies did not report or recognize.

6. Evaluating the risk of HIV transmission in dental settings has included data from CDC's surveillance activities of health-care workers, HIV seroprevalence studies conducted by the American Dental Association among dental workers' prospective studies that evaluate the risk of seroconverting following an exposure to HIV-infected blood (CDC Needlestick study), and studies that attempt to define the frequency and circumstances of blood contacts in dental settings.

7. As of 1993, approximately 86% of currently practicing U.S. dentists had received the hepatitis B vaccination. A recent study suggests that the vaccination will only be effective in 88% of the dentists who receive the three doses of the vaccination. Dentists under the age of 45 years were 2.5 times more likely than dentists greater than 45 years to be vaccine responders.

8. Dr. Kuvin suggests that the practice of dentistry involves greater exposure to blood than the practice of most surgeons. I know of no study which supports this suggestion.

9. There is a difference bewteen "being at high risk for TB infection" and "being at high risk for progression from latent TB infection to active disease." Dr. Kuvn inaccurately conflates these risks.

10. Epidemiologic studies do not indicate that persons with HIV/AIDS are at increased risk for TB infection. The majority of persons in the United States infected with HIV are not infected with TB, and the majority of persons in the United States infected with TB do not have HIV/AIDS. Groups of persons known to have a higher prevalence of TB infection include the elderly, foreign-born persons from areas of the world with a high prevalence of TB (e.g., Asia, Africa, the Caribbean, and Latin America), medically underserved populations, homeless persons, alcoholics, injecting-drug users, and residents and employees of high-risk congregate settings (e.g., correctional institutions, nursing homes, and mental health institutions.

11. Persons with HIV/AIDS are at high risk for progression from latent TB infection to active disease. In other words, if persons with HIV/AIDS are exposed to the TB bacillus and become infected, they are at greater risk than members of the general population for progressing from latent (inactive) TB infection to active TB disease. Other groups at higher risk for progression from latent TB infection to active disease include persons who have been infected with TB recently (i.e., within the previous 2 years), children less than four years of age, and persons with certain medical conditions

(e.g., chronic renal failure with renal dialysis, diabetes mellitus, and immunosuppression from chemotherapy).

12. The CDC recommends that all persons referenced in paragraphs 10 and 11 receive a PPD-tuberculin skin test on a yearly basis.

13. The CDC has never stated that all persons with HIV should be referred to an appropriately TB-engineered facility for dental treatment.

14. Current CDC guidelines state that patients suspected of having undiagnosed active TB should be referred to a physician for medical evaluation. Suspicion of TB should be based on a patient's medical history (i.e., whether they have a history of TB disease) and whether they have symptoms suggestive of TB (cough, night sweats, bloody sputum, anorexia, and fever), not solely or a patient's HIV status. If the patient is diagnosed by his or her physician as having active TB, dental treatment should be deferred until the patient no longer is infectious. Only if a patient requires emergency dental care should he or she be treated in a facility that can provide TB isolation.

15. If Dr. Bragdon wishes to screen out all persons from his dental practice who are "at risk" for TB, he should screen out not only persons with HIV/AIDS, but all persons who the CDC considers to be "at risk," including the elderly, persons with cancer who are immunocompromised, and residents of mental health institutions. Based on information provided to me, it is my understanding that Dr. Bragdon provides dental treatment to these patient populations and does not refer them to appropriately TB-engineered facilities.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

Executed on
October 18, 1995 s/Donald Wayne Marianos
Dr. Donald Wayne Marianos

Centers

Director, Division of Oral Health

for Disease Control and Prevention
NCPS/DOH
1600 Clifton Road, N.E.
Mail Stop F-10
Atlanta, Georgia 30333

FOURTH DECLARATION OF
OF DONALD WAYNE MARIANOS, D.D.S., M.P.H.

(Caption omitted in printing)

Pursuant to 28 U.S.C. § 1746, I Donald Wayne Marianos, D.D.S., M.P.H. declare that:

I am a Captain in the United States Public Health Service ("USPHS") at the Centers for Disease Control and Prevention ("CDC"), and am the Director of the Oral Health Program. I am testifying in this case in my official capacity. My testimony in this declaration, as in my prior declarations, is on behalf of and represents the views of the CDC.

I have read, and am familiar with, the articles cited in Defendant's Rule 60 Motion for Relief from Order and Incorporated Memorandum of Law. The majority of these articles were published in the early 1990's, and my prior testimony took into account the results of the studies reported in those articles. Nothing published since October 18, 1995 (the date of my last declaration) would cause me to alter, in any way, my prior testimony to this Court.

1. It remains the view of the CDC that it is safe to provide routine dental care to patients with HIV and AIDS in private dental offices when universal precautions are utilized.

2. It remains the view of the CDC that the provision of routine dental care to persons with HIV or AIDS requires no additional procedures beyond the CDC recommendations.

3. It remains the view of the CDC that the risk of HIV-transmission in the health care setting is very low; that, in a dental setting, the risk of HIV transmission from patient to provider is so low as to be unquantifiable; and that, when implemented, the CDC recommendations reduce the already low risk of disease transmission in the dental environment, from either patient to dental health care worker, dental health care worker to patient, or patient to patient.

4. It remains the view of the CDC that it is safe to provide dental care to patients with AIDS, including those who are in the final stages of AIDS, in private dental offices when universal precautions are utilized. The MMWR report of December 22, 1995 (Exhibit 9 to Defendant's Rule 60(b) Motion) does not suggest otherwise. The MMWR report provides additional evidence corroborating the low risk of HIV transmission in the health care setting, and further supports our conclusion that the risk of transmission in dentistry is very low. Assuming this very low risk, the MMWR study further breaks down the factors identified with transmission. One of these factors is the stage of disease, because there is a direct relationship between the stage of disease and the viral titer (number of pathogens in an infected individual). But the viral titer is only one component of the multifactorial chain of disease transmission. The efficacy of universal precautions is in no way affected by the stage of the patient's disease. The MMWR study's identification of this factor in no way challenges the CDC's conclusion that people in the final stages of AIDS can be safely treated in a private dental office so long as universal precautions are utilized.

5. The Hepatitis studies referred to in Bragdon's Rule 60 motion must be placed in proper perspective. Hepatitis is 100 times more infective than HIV. The studies refer to thoracic surgery and cardiac surgery, which the articles themselves describe as highly invasive and of long duration. Yet, since 1987, when dentists routinely began to use universal precautions, there has not been one documented case of Hepatitis transmission in dentistry. And, as I testified previously, there has never been a documented case of HIV transmission from patient to dentist, or from infected patient to non-infected patient, in the dental health care setting.

6. It is the position of the CDC, the Association of State and Territorial Health Officials, the Association of State and Territorial Dental Directors, and other recognized public health organizations of which I, personally, am aware that universal precautions are an effective form of infection control, and that it is safe to treat individuals with HIV and AIDS in a private dental setting.

I hereby declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief.

Executed on
April 1, 1996

s/Donald Wayne Marianos
Dr. Donald Wayne Marianos
Centers for Disease Control and Prevention
1600 Clifton Road, N.E.
Mail Stop F-10
Atlanta, Georgia 30333

FINAL JUDGMENT
DATED APRIL 22, 1996

[U. S. DISTRICT COURT
DISTRICT OF MAINE]

[ABBOTT V. BRAGDON]

[Caption omitted in printing]

The Court having ruled on all pending claims and motions in its Orders dated December 22, 1995, and April 22, 1996, judgment shall enter in the above-captioned matter in favor of Plaintiffs against the Defendant.

Dated at Bangor, Maine, on April 22, 1996

/s/Morton A. Brody, United States District Judge

JUDGMENT

[UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT]

Entered March 5, 1997

[ABBOTT V. BRAGDON]

[Caption omitted in printing]

This cause came on to be heard on appeal from the United States District Court for the District of Maine, and was argued by counsel.

Upon consideration whereof, it is now here ordered, adjudged and decreed as follows: The judgment of the District Court is affirmed.

By the Court
/s/ William H. Ng, Clerk

WEDNESDAY, NOVEMBER 26, 1997

CERTIORARI GRANTED

97-156 BRAGDON, RANDON V. ABBOTT, SIDNEY, ET AL.

The petition for a writ of certiorari is granted limited to Questions 1, 2, and 3 presented by the petition. The brief of petitioner is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, January 9, 1998. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, February 6, 1998. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, March 6, 1998. Rule 29.2 does not apply.

(8)

Supreme Court, U.S.
FILED
JAN 7 1998
CLERK

No. 97-156

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1997

RANDON BRAGDON, D.M.D.

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE PETITIONER

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER, Ph.D.
RUDMAN & WINCHELL, LLC
Attorneys for Petitioner
84 Harlow Street
Bangor, Maine 04401
Telephone: (207) 947-4501

69 pp

QUESTIONS PRESENTED

1. Is reproduction a major life activity within the meaning of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101-12213?

2. Are asymptomatic individuals infected with HIV per se disabled within the meaning of the ADA?

3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedure on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?

PARTIES

The parties before the United States Court of Appeals for the First Circuit were appellee Sidney Abbott, appellee The Maine Human Rights Commission, and appellant Randon Bragdon, D.M.D.

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Taunya L. Banks, *The Americans with Disabilities Act and the Reproductive Rights of HIV-Infected Women*, 3 Tex. J. Women & L. 57 (1994) 6

Transcript of Oral Argument (U.S. No. 85-1277 Dec. 3, 1986) 17

United States Dep't of Commerce, Bureau of the Census, *Americans With Disabilities: 1991-1992* (1993) 33

Yunzhen Cao, et al., *Virologic and Immunologic Characterization of Long-Term Survivors of Human Immunodeficiency Virus Type 1 Infection*, 332 N. Eng. J. Med. 201 (1995) 3

OPINIONS BELOW

The opinion of the Court of Appeals for the First Circuit is reported at 107 F.3d 934 (1st Cir. 1997) (Pet. App. 1a-30a). The opinion of the United States District Court, District of Maine, is reported at 912 F. Supp. 580 (D. Me. 1995) (Pet. App. 31a-65a).

JURISDICTION

The Appeals Court entered judgment on March 5, 1997, and denied petitioner's petition for rehearing on April 22, 1997. The petition for writ of certiorari was filed on July 21, 1997, and was granted on November 26, 1997. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The statutes and regulations directly involved in this case are 42 U.S.C. § 12101(2), 42 U.S.C. § 12182(b)(3), 28 C.F.R. § 36.104 (list of major life activities under definition of disability), and 28 C.F.R. § 36.208(c). They are reprinted in the appendix to this brief and at Pet. 1-2.

STATEMENT

1. *AIDS and HIV.* Acquired immunodeficiency syndrome (AIDS) is a condition that occurs in individuals infected with the human immunodeficiency virus (HIV). *See generally* Mitchell Katz & Harry Hollander, *HIV Infection*, Current Medical Diagnosis & Treatment 1204 (1998). AIDS is not a disease itself, but a set of

signs and/or symptoms that occur together. The "hallmark of symptomatic HIV infection is immunodeficiency." *Id.* at 1207. With immune depression, diseases that do not affect a person with a healthy immune system can be devastating. *Id.*[1]

The clinical definition of AIDS has evolved over the past decade. In 1993, the Centers for Disease Control and Prevention (CDC) expanded the definition of AIDS to include persons infected with HIV and who have ever had a CD4 lymphocyte count below 200 cells/μL or a CD4 lymphocyte percentage below 14%. *Id.* at 1204. The new definition of AIDS was also expanded to include HIV-infected persons with pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer. *Id.* The definition continues to include persons with any of a lengthy list of various opportunistic infections (e.g., pneumocystis pneumonia) and neoplasms (e.g., Kaposi's sarcoma), as well as HIV-infected persons with documented weight loss, diarrhea, or dementia. *Id.*

The "earliest stages of HIV infection may be unapparent or may be expressed in symptoms similar to those of many other viral infections, including mild fever, malaise, and swollen lymph nodes." 1 *Magill's Medical Guide: Health and Illness* 10 (1995). Diagnostic blood tests to detect HIV actually detect HIV antibodies. When an individual is infected with HIV, it can be several

[1] In addition to HIV-1, the predominate form of HIV in the United States, a group of related viruses, HIV-2, have been isolated in West African patients. *Id.*

months before the development of antibodies. During this time, a person infected with HIV may test negative, but actually be infected with HIV. *Id.* at 10-11. A "small incidence of individuals (< 1%) are infected with HIV for up to 36 months without generating an antibody response." Katz & Hollander, *supra*, at 1216.

Approximately five percent of individuals infected with HIV have "remained clinically healthy and immunologically normal for more than a decade." Yunzhen Cao, et al., *Virologic and Immunologic Characterization of Long-Term Survivors of Human Immunodeficiency Virus Type 1 Infection*, 332 N. Eng. J. Med. 201, 201 (1995). In fact, the "median interval between infection and the development of AIDS has been 10 years." Review, *HIV and Pregnancy*, 103 Br. J. Obstet. Gynaecol. 1184, 1185 (1996). Thus, "[m]any individuals with HIV remain asymptomatic for years, with a mean time of approximately 10 years between exposure and development of AIDS." Katz & Hollander, *supra*, at 1208. During this period, many asymptomatic individuals with HIV remain clinically healthy and immunologically normal. Cao et al., *supra*, at 201. As the word itself connotes, *asymptomatic* HIV infection does not substantially limit a person's ability to care for one's self, perform manual tasks, walk, see, hear, speak, breathe, learn, or work.

Famous examples in the popular culture of asymptomatic persons with HIV are basketball great Earvin "Magic" Johnson and four-time Olympic gold-medal diving champion Greg Louganis. Mr. Louganis recounts in his

autobiography what it was like to compete in the Seoul 1988 Summer Olympics, and win two gold medals in diving, knowing that he was infected with HIV. Greg Louganis, *Breaking the Surface* 3-13, 198-213 (1995). Mr. Johnson recounts in his autobiography what it was like to play in the NBA and win an Olympic gold medal in basketball, knowing he was infected with HIV. Earvin "Magic" Johnson, *My Life* 320-346 (1992).

HIV can be transmitted by percutaneous and mucocutaneous exposure to HIV-infected blood and visibly bloody fluids. Laurie Robert & David Bell, *HIV Transmission in the Health-Care Setting*, 8 Infectious Disease Clinics of N. America 319, 319-321 (1994).[2] "Percutaneous exposures" include exposures caused by puncture or cut injuries, and "mucocutaneous exposures" include mucous membrane exposures to the tissues of the eyes, nose, and throat. The occupational risk of HIV infection after percutaneous exposure to HIV-infected blood has been estimated as, on average, 0.3%. *Id.* at 324 (Appeals Court App. 177). Injury with a device visibly contaminated with the source patient's blood is a significant factor increasing the risk of infection after percutaneous exposure.[3] The occupational risk of HIV infection after a mucous membrane exposure to HIV-infected blood has been estimated as, on average, approximately 0.09%. Robert & Bell, *supra*, at 324. Cases of "transmission of HIV infection after skin exposures

[2] Reprinted in part at Pet. App. 104a-109a. Reprinted in full at Appeals Court App. 174-179.

[3] Denise Cardo, et al., *A Case-Control Study of HIV Seroconversion in Health Care Workers After Percutaneous Exposure*, 337 N. Engl. J. Med. 1485, 1488 (1997).

also have been documented," but the risk for transmission after "skin exposures, whether to intact or nonintact skin, has not been precisely quantified." Denise Cardo & David Bell, *Bloodborne Pathogen Transmissions in Health Care Workers*, 11 Infectious Disease Clinics of North America 331, 333 (1997).

CDC has confirmed HIV transmissions from a dentist to six patients (Pet. App. 111a-1 - 132a), and courts have deemed significant the risk of HIV transmission from health care workers, including a dentist, to patients, *e.g.*, *Doe v. University of Md. Med. Sys. Corp.*, 50 F.3d 1261 (4th Cir. 1995); *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993), *cert. denied*, 510 U.S. 1119 (1994); *Doe v. Washington Univ.*, 780 F. Supp. 628 (E.D. Mo. 1991). Experts agree that the risk to the dentist is greater than to the patient. (Pet. App. 137a, 139a).[4]

2. *HIV and Pregnancy.* Recent studies indicate that "pregnancy does not appear to accelerate [HIV] disease progression, except in women with symptomatic infection or low CD4 counts." Rachana Kumar, et. al., *Impact of Pregnancy on Maternal AIDS*, 42 J. Repro. Med. 429, 429, 433 (1997) (commenting that studies in developed countries have failed to corroborate that pregnancy accelerates AIDS and reduces survival time); *see also HIV and Pregnancy*, *supra*, at 1185 (pregnancy "does not seem to have any long term effect on the rate of decline [of the CD4 lymphocyte

[4] *See also* Aug. 10, 1995, deposition of Donald Marianos, D.D.S., pp. 55-58, reprinted at Appeals Court App. 212.

count]," and "the survival time of patients with AIDS was not affected by pregnancy in a small study").

Thirteen years ago the CDC recommended that counselors advise HIV-infected women "to consider delaying pregnancy until more is known about perinatal transmission of [HIV]."[5] Some states' department of health materials went further and recommended that HIV-infected women should not become pregnant.[6] The view that HIV-infected women should be discouraged from having children has been criticized in light of more recent studies and on moral and philosophical grounds.[7]

For example, authors have compared some public health officials' opinions about pregnancy and HIV-infected women, with the case of Buck v. Bell, 274 U.S. 200 (1927), in which the Court deferred to the views of respected public health officials in Virginia, that a young, mentally retarded woman should be involuntarily sterilized. Levine & Dubler, *supra* n.7, at 338. The authors point out that many women with chronic diseases, and some who are dying, choose to become

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[5] *Recommendations for Assisting in the Prevention of Perinatal Transmission of [HIV]*, 34 Morbidity & Mortality Weekly Report 721, 725 (1985).

[6] Ronald Bayer, *AIDS and the Future of Reproductive Freedom*, 68 Milbank Q. 179 (1990).

[7] *See, e.g.*, Taunya Banks, *The [ADA] and the Reproductive Rights of HIV-Infected Women*, 3 Tex. J. Women & L. 57 (1994); Carol Levine & Nancy Dubler, *Uncertain Risks and Bitter Realities: The Reproductive Choices of HIV-infected Women*, 68 Milbank Q. 321 (1990); John Arras, *AIDS and Reproductive Decisions*, 68 Milbank Q. 353 (1990).

pregnant, even at considerable risk to themselves, or offspring, and they are more treasured for doing so. *Id.* at 323 (citing the popular film *Steel Magnolias* as a celebration of this theme).

Current studies show that the risk of HIV transmission from infected mother to child is approximately 8% if the pregnant woman undergoes AZT therapy, and approximately 25% otherwise. *HIV and Pregnancy*, *supra*, at 1186-87. (J.A. 52-53)

CDC has issued revised recommendations for counseling HIV-infected women. *Recommendations for [HIV] Counseling and Voluntary Testing for Pregnant Women*, 44 Morbidity & Mortality Weekly Report, No. RR-7 (July 7, 1995). They state that reproductive counseling for HIV-infected women should be "nondirective." *Id.* at 10. Health-care providers "should be aware of the complex issues that HIV-infected women must consider when making decisions about their reproductive options and should be supportive of *any* decision." *Id.* (emphasis added).

3. *This Case and Proceedings Below.* On September 16, 1994, respondent Sidney Abbott arrived at the private dental office of petitioner Randon Bragdon, D.M.D., in Bangor, Maine, for an appointment. On her patient registration form, Ms. Abbott indicated that she was infected with HIV. (J.A. 50) Ms. Abbott was asymptomatic at the time. (J.A. 10, 14, 49-50)

Ms. Abbott was brought into the treatment area and seated in a dental chair. Dr. Bragdon

performed a routine, diagnostic dental examination and discovered that she had a cavity near the gum line on a back, lower tooth. He told her that, pursuant to his infectious disease policy, he would not fill the cavity in his office, but would fill it in a hospital setting. Ms. Abbott said she would think about it and get back to him. (Pet. App. 80a)[8]

Ms. Abbott thereupon sued Dr. Bragdon in the United States District Court, District of Maine ("District Court") for disability discrimination under title III of the Americans with Disabilities Act (ADA). Title III prohibits discrimination by private entities in places of public accommodation.

Ms. Abbott originally argued that the *only* relevant fact about her condition is "that she's HIV positive." (J.A. 12) Her attorney instructed her not to answer any question that would reveal anything about her individual medical history. (J.A. 13) Later, Ms. Abbott took the position that she is disabled also "because she decided not to have children because of the risk of transmitting HIV to her child," *Mot. for S.J.* at 21 (Sept. 19, 1995). (J.A. 14)

Dr. Bragdon argued that Ms. Abbott was not disabled under the ADA, and even if she were, he was under no legal obligation to fill her cavity in his office because, in his judgment, the invasive procedures necessary to do so would have posed a direct threat to the health and safety of others, including himself. *See* 42 U.S.C. § 12182(b)(3).

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[8] Ex. E of Def.'s Sept. 19, 1995, Statement of Material Facts.

The District Court ruled that Ms. Abbott was disabled. It said the "position taken by [Dr. Bragdon] is not an unreasonable one," but granted summary judgment for Ms. Abbott because Dr. Bragdon failed to demonstrate that affidavits of Donald Marianos, D.D.S., M.P.H., of CDC, were "medically unsupportable." (Pet. App. 51a, 63a)

The United States Court of Appeals for the First Circuit (the "Appeals Court") explained that the question of whether reproduction is a major life activity for purposes of the ADA "is very close," but in its opinion, reproduction and "the bundle of activities that it encompasses" are major life activities under the ADA. (Pet. App. 7a, 11a) The Appeals Court implied that on the basis of legislative history, it was prepared to rule in the alternative that all asymptomatic individuals infected with HIV are disabled. (Pet. App. 15a)

With respect to the issue of direct threat, Dr. Bragdon argued that it was unfair and contrary to law to defer to the affidavits of Dr. Marianos when they post-date Ms. Abbott's appointment and contain opinions absent and different from views expressed in official, published CDC materials. Dr. Bragdon also argued that courts should defer to private health care providers' judgments, as long as they are reasonable in light of then-current medical knowledge.

The Appeals Court partially disagreed with respect to the Marianos affidavits, noting they are of "limited value." (Pet. App. 23a n.7) The Appeals Court completely disagreed with respect to the question of deference, granting a continuing

presumption of correctness to conclusions which it said "seem to be implicit" (Pet. App. 23a) in *Recommended Infection-Control Practices for Dentistry, 1993*, 41 Morbidity & Mortality Weekly Report, No. RR-8 (Pet. App. 181a-199a). The seemingly implicit conclusions identified by the Appeals Court are that no further risk-reduction measures are desirable for dental workers when treating HIV-infected patients than those measures recommended by CDC for all patients, and that filling cavities of patients known to be infected with HIV is generally safe. (Pet. App. 23a)

After reviewing the record, the Appeals Court affirmed summary judgment for Ms. Abbott, deciding that Dr. Bragdon failed to raise a genuine issue of fact by presenting sufficient countervailing evidence to rebut the presumption of correctness attached by it to the seemingly implicit CDC conclusions.

4. *The Dispute Over Direct Threat.* The parties disagree about the nature and significance of the risk of transmission of HIV from a patient, such as Ms. Abbott, to a dentist, such as Dr. Bragdon, while performing procedures necessary to fill a cavity on a back lower tooth, near the gum line. The parties also dispute the significance of the risk of active tuberculosis (TB) in HIV-infected individuals, and what are reasonable precautions that a dentist may take while performing cough-inducing and aerosol-generating procedures on *all* HIV-infected individuals. (Pet. App. 152a-154a)

Dr. Bragdon's understanding is that the Court does *not* intend to consider whether, in this

particular case, Dr. Bragdon raised a genuine factual issue for trial as to whether his judgment on September 14, 1994, was within a range of reasonable professional judgment, given then-current medical knowledge.[9] The Court appears to have indicated, instead, that it will consider the purely legal question of whether, *assuming* a private health care provider makes a reasonable professional judgment, may he nonetheless be liable under title III of the ADA for disability discrimination on account of conflicting implicit views of one or more public health officials.

If this is true, and if the Court rules that deference should be given to the reasonable judgments of private health care providers, or that the legal presumption applied against Dr. Bragdon by the Appeals Court is otherwise erroneous, then the Court can, and presumably will return the case to the lower courts for application of the correct legal standard, and a decision under it of whether Dr. Bragdon raised a genuine issue for trial, or whether either party should prevail by summary judgment. To the extent, then, that this is the posture of the case, there is no reason for Dr. Bragdon to detail the evidence summarized in his petition for writ of certiorari, pages 13-22, supporting the conclusion that he made a reasonable, professional judgment of direct threat.[10]

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[9] Dr. Bragdon's understanding is based on the Court's limited grant of certiorari which excluded petition Question 5.

[10] Dr. Bragdon does reserve the right to brief these factual issues in reply. Dr. Bragdon's basis for concern is that Ms. Abbott's Rule 26 designation of additional parts of the record to be included in the joint appendix, and her counsel's

SUMMARY OF ARGUMENT

1. Actual "disability" under the ADA is defined as an impairment that substantially limits one or more major life activities. The regulation's examples of major life activities are caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Asymptomatic individuals infected with HIV are not in any ordinary sense substantially limited in the ability to care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, or work. Many with HIV would take offense at the blanket assumption they are disabled, and be critical of those who confound AIDS and HIV infection. The ADA itself is designed to prevent such false presumptions. Asymptomatic HIV-infection is therefore *not* per se an actual disability under the ADA.

2. Proponents of the view that all asymptomatic HIV-infected individuals are disabled under the ADA rely on two arguments.

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statements to the undersigned when questioned about that designation, indicated a preliminary intent to argue before the Court facts pertaining to the quantitative and qualitative risk of transmission of HIV and TB to dentists. Dr. Bragdon also anticipates the possibility of many well-meaning *amicus curiae* briefs which will argue facts relating to direct threat. For these reasons, Dr. Bragdon is compelled to reserve his rights on this issue, and will reassess after reviewing the opposition briefs, whether it is necessary to argue any evidentiary details supporting the reasonableness of his judgment and the existence *vel non* of a direct threat in this case.

The first argument is that all asymptomatic HIV-infected individuals are actually disabled because HIV infection is a physical impairment that substantially limits their intimate sexual relations and/or ability to reproduce. This argument is without merit for several reasons. *First*, as to medical fact, the argument is incorrect, even for women of child bearing age. Asymptomatic HIV-infection is not a substantial *physical* limitation on their ability to have intimate sex and/or reproduce. *E.g.*, Kumar, et. al., *supra*, at 433. *Second*, the argument confuses moral decision-making for physical disability. Asymptomatic HIV-infected women of child bearing age make different culturally and morally informed decisions concerning sex and pregnancy, but that does not make some disabled, and others not. *Third*, sexual intercourse without barrier protection and/or reproduction are not major life activities for the purpose of defining disability under the ADA.

The second argument that all asymptomatic HIV-infection individuals are disabled is that the legislative history says they are. This argument is without merit because the definition is plain that there are no per se disabilities. Even if it were not, the legislative history repeatedly equivocates on whether all asymptomatic individuals with HIV are disabled under the ADA. Members of Congress can have no reasonable expectation that courts will elevate portions of committee reports and floor debates to the status of a statute when the reports and statements do violence to the plain wording of the statute on a politically difficult issue, and when they are based on false presumptions concerning the physical effects of HIV.

3. When people at random are asked whether reproduction is a major life activity, many, especially those raising small children, say it is. Many without children believe it is not. The role of the Court, however, is not to poll the man in the street, nor to defer to its own first reactions, either way. The role of the Court is to look at the object and policy of the ADA as a whole. When it does, the Court will find that the focus of the ADA is on public, not private family life. The Court will conclude that it is neither coincidence, nor forgetfulness, that specifically reproductive disorders are never discussed or treated as disabilities, and that sexual activity and reproduction never appear on Congressionally approved regulatory lists of major life activities.

4. The most sensible decision for the Court is that a currently asymptomatic person infected with HIV is disabled *if* a would-be defendant regards the infection as substantially limiting in a pertinent major life activity, or *if* the HIV has caused the person to have a record of substantial limitation in a major life activity. In other words, many HIV-infected persons, including those without symptoms, will be protected under the ADA, but asymptomatic HIV infection is not automatically a disability.

5. Between 1984 and Ms. Abbott's September 16, 1994, dental appointment, Dr. Bragdon participated in approximately 32 professional continuing education courses relating to infection control, HIV, and/or treatment of persons with HIV

and AIDS.[11] On September 16, 1994, he made what he thought was a reasonable professional judgment based on, *inter alia*, CDC reports of HIV transmission in the dental setting, CDC reports of occupational transmission of HIV to health care workers, and his ethical obligation to fill his patient's cavity.

If Dr. Bragdon made a reasonable professional judgment, he should not be liable for disability discrimination under title III, and especially not on the basis of what merely seems implicit in CDC guidelines.

Consistent with title III regulations, if Ms. Abbott is disabled, the Court should remand for a factual determination as to whether Dr. Bragdon's judgment was within a reasonable professional range, given then-current medical knowledge. If the real dispute is over public health value tradeoffs given a small, but identifiable risk to dentists such as Dr. Bragdon, then Dr. Bragdon should not be liable if he acted in good faith, and a reasonable dentist in his shoes could deem the risk personally significant. In other words, the Court should not impute to Congress the intent to abrogate private professional judgments, and to compel health care workers to take personally significant risks, on the basis of non-committal health authority guidelines. The police power of the State includes the power to compel citizens to take risks, but this should be done by express legislation, or formal rulemaking, where relevant

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[11] Third Affidavit of Randon Bragdon ¶¶ 2-3 (Oct. 19, 1995), filed in the District Court on October 20, 1995.

facts and value tradeoffs can be articulated and debated.

ARGUMENT

I. THE PLAIN WORDING OF THE ADA SHOWS THAT HIV INFECTION IS NOT A PER SE DISABILITY.

A cardinal canon of statutory interpretation is that "courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992); *see TVA v. Hill*, 437 U.S. 153, 173 (1978) (courts may not ignore plain language in a statute); *cf. Southeastern Community College v.* Davis, 442 U.S. 397, 405 (1979) (starting point for construction of a statute is always the language itself).

The ADA says that an individual may be disabled in one of three senses. An individual is actually disabled if the individual has a "physical or mental impairment that substantially limits one or more major life activities." 42 U.S.C. § 12102(2)(A). An individual is also disabled if the individual is not currently limited in a major life activity, but either has a record of an impairment substantially limiting a major life activity, or is regarded as having an impairment substantially limiting a major life activity. 42 U.S.C. § 12102(2)(B) & (C).

In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), the Court considered a virtually identical, three-prong definition of handicapped for

use in section 504 of the Rehabilitation Act of 1973 (the "Rehabilitation Act").[12] The Court granted certiorari in *Arline* on whether tuberculosis (TB) is a handicap under the Rehabilitation Act, and the Eleventh Circuit opinion under review loosely seemed to indicate that *all* people with TB are handicapped. *See Arline v. School Bd. of Nassau County*, 772 F.2d 759, 763 (11th Cir. 1985); Tr. of Oral Arg. 28-29 (No. 85-1277) ("Q: [O'Connor, J.,] . . . as I understand it, the Eleventh Circuit held that all people with tuberculosis are handicapped"). Ms. Arline's brief also suggested that TB is per se a handicap. *See* Resp't Br. at 12 (No. 85-1277).

At oral argument Ms. Arline conceded that not all people with TB are handicapped. Tr. of Oral Arg. 29 ("Q: [O'Connor, J.,] . . . Do you agree with me, then, that not all people with tuberculosis are handicapped? A: I certainly agree"). Petitioners conceded that Ms. Arline *was* handicapped because of her record of hospitalization on account of the debilitating effects of TB. Tr. of Oral Arg. 12, 17, 52-53; J.A. 11 (testimony that Ms. Arline had a record of being hospitalized on account of the acute effects of TB on her respiratory system).

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[12] ADA regulatory guidelines and legislative history specifically endorse the Department of Health, Education, and Welfare's (HEW's) analysis of "individual with a handicap" in HEW's regulations, 42 Fed. Reg. 22676, 22685 (May 4, 1977), implementing § 504. *See* 28 C.F.R. Pt. 36, App. B § 104 (citing 1977 HEW regulations and ADA House Educ. and Labor Comm. Rep. at 50). The term "disability" now replaces the term "handicap" in the Rehabilitation Act, 29 U.S.C. § 706(8)(B).

The Court thereupon framed the question as whether persons with TB, a contagious disease, *may* be handicapped under the Rehabilitation Act. *Arline*, 480 U.S. at 275. The Court held that they may, and found that Ms. Arline was handicapped because of her record of an impairment substantially limiting a major life activity. *Arline*, 480 U.S. at 281. Implicit in the Court's decision is that TB, a contagious disease, is not always a handicap, and that an individual with TB is not handicapped under the first prong of the definition unless she has a physical or mental impairment that substantially limits a major life activity.

The same analysis applies to HIV. HIV infection is not automatically a disability. When it substantially limits a major life activity, it is. When it is asymptomatic, it is not a disability, unless there is a record of substantial limitation of a major life activity, or the would-be defendant regards the infection as substantially limiting in a pertinent major life activity. *See Ennis v. National Ass'n of Bus. & Radio, Inc.*, 53 F.3d 55, 59-60 (4th Cir. 1995) (HIV infection is not per se a disability, and the "plain language of [42 U.S.C. § 12102(2)] requires that a finding of disability be made on an individually-individual basis").[13]

[13] Some immunologic defects caused by HIV are "explained not by *quantitative* abnormalities of lymphocyte subsets but by *qualitative* defects in CD4 responsiveness induced by HIV." Katz & Hollander, *supra*, at 1207. If an asymptomatic HIV-infected plaintiff does not, however, present any evidence of the HIV's detrimental physical impact on her, either quantitatively or qualitatively, then she cannot properly be found even to have a "physical impairment." *See Runnebaum v. Nationsbank of Md., N.A.*, 123 F.3d 156, 169-70 (4th Cir. 1997) (en banc) (asymptomatic HIV-infected plaintiff failed to show that the HIV-infection was an impairment). Ms. Abbott did not introduce any evidence as to a quantitative or qualitative impairment of her immune system. For that reason, summary judgment for Dr. Bragdon is appropriate.

The Court should not go beyond the plain language of 42 U.S.C. § 12102(2), in order to decide that HIV, like any other virus or condition, is not per se a disability, and that a plaintiff with HIV is not disabled under 42 U.S.C. § 12102(2)(A) unless she demonstrates that she has a physical or mental impairment that substantially limits a major life activity.

II. LEGISLATIVE HISTORY DOES NOT ESTABLISH THAT HIV-INFECTION IS A PER SE DISABILITY.

The Senate Labor and Human Resources Committee Report on the definition of disability under the ADA (the "ADA Senate Report") states: "It is the Committee's intent that the analysis of the term 'individual with handicaps' . . . by the Department of Housing and Urban Development [HUD] of the regulations implementing the Fair Housing Amendments Act of 1988 apply to the definition of the term 'disability' included in this legislation." S. Rep. No. 101-116, 101st Cong., 1st Sess. 21 (1989).

The HUD regulations implementing the Fair Housing Amendments Act of 1988 (the "1988 Act") specifically discuss the question of whether persons infected with HIV "are understood to be persons with a 'handicap' protected by the Act." 54 Fed. Reg. 3232, 3245 (Jan. 23, 1989). The

HUD regulations refer to *Arline* and to many statements in the 1988 Act's legislative history indicating that HIV-infected persons are protected. "In light of these authorities," HUD says, it "has added [HIV] to the illustrative list of 'physical or mental impairments' in the final rule's definition of handicap." *Id.* "Physical or mental impairments" are distinct from "handicaps" in the 1988 Act's definition of "handicap", 42 U.S.C. § 3602(h), just as "physical or mental impairments" are distinct from "disabilities" in the ADA's definition of "disability," 42 U.S.C. § 12102(2). Physical or mental impairments of any kind are not handicaps or disabilities unless and until they also substantially limit a major life activity. The HUD analysis, therefore, plainly stops short of defining HIV as a per se handicap. HUD recognizes HIV as an impairment, but not as a handicap. This analysis of HIV infection comports with the Court's analysis in *Arline*, with the medical fact that not all HIV-infected persons are substantially limited in a major life activity, and with the plain wording of the 1988 Act.

The ADA Senate Report explicitly endorses this HUD analysis. According to this legislative history, HIV infection is not per se a disability, but rather one example among many of a physical impairment that may, in appropriate circumstances, trigger a disability.

Like the ADA Senate Report, the ADA House Education and Labor Committee, Judiciary Committee, and Energy and Commerce Committee Reports all explicitly endorse this HUD analysis which recognizes HIV as an impairment, but not as

a handicap. The Education and Labor Committee Report states: "It is the Committee's intent that the analysis of the term 'individual with handicaps' . . . by the Department of Housing and Urban Development of the regulations implementing the Fair Housing Amendments Act of 1988 (54 Fed. Reg. 3232 *et seq.* (Jan. 23, 1989)) apply to the definition of the term 'disability' included in this legislation." H. Rep. No. 101-485(II), 101st Cong., 2d Sess. 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 332.[14]

Like the ADA Senate Report, these sources of legislative history also treat HIV as an impairment that may trigger a disability, but not a per se disability.

Ms. Abbott will point out that the ADA Senate Report also states: "As noted by the U.S. Department of Justice, 'Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals,' September 27, 1988, at 9-11, a person infected with [HIV] is covered under the first prong of the definition of the term 'disability.'"

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[14] The Judiciary Committee Report states that the "Committee intends that the analysis of . . . the term 'handicap' contained in the primary regulations implementing the Fair Housing Amendments Act of 1988, apply to the definition of 'disability' in the ADA." H. Rep. No. 101-485(III), 101st Cong., 2d Sess. 26-27, *reprinted in* 1990 U.S.C.C.A.N. 445, 449. The Energy and Commerce Committee Report states that the definition of disability in the ADA is intended to have "the same meanings given to the corresponding provisions used in the definition of . . . the term 'handicaps' in section 802(h) of the Fair Housing Act, and in regulations issued under those statutes." H. Rep. No. 101-485(IV), 101st Cong., 2d Sess. 36, *reprinted in* 1990 U.S.C.C.A.N. 512, 525.

S. Rep. No. 101-116, 101st Cong., 1st Sess. 22 (1989).

The Justice Department document to which the ADA Senate Report refers is a memorandum prepared for Arthur B. Culvahouse, Jr., then Counsel to the President, by then acting Assistant Attorney General Douglas Kmiec (the "Kmiec Memorandum"). The Kmiec Memorandum does not purport to be a definitive interpretation of the Rehabilitation Act, but instead offers predictions on how courts will rule on the question of whether asymptomatic persons with HIV are handicapped. *See Runnebaum v. Nationsbank of Md., N.A.*, 123 F.3d 156, 170-71 (4th Cir. 1997) (en banc).

The Kmiec Memorandum notes that "*Arline* did not resolve the application of section 504 to *asymptomatic* HIV-infected individuals," and that asymptomatic persons with HIV do not seem to be disabled in the normal sense of the word. Kmiec Memorandum § II.B, pp. 6, 9. The Memorandum nonetheless predicts that courts will decide that asymptomatic HIV-infected persons are substantially limited in procreation and intimate personal relations. *Id.* § II.B.2, pp. 9-11.[15]

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[15] Two years earlier, then Assistant Attorney General Charles Cooper, writing for the Justice Department, stated: "Which brings us to the central proposition of our analysis: that persons who are infected with [HIV] but have no symptoms of the disease are not handicapped [under the first prong of the definition of handicap for use in § 504]." Charles Cooper, Office of Legal Counsel, U.S. Dep't of Justice, *The Justice Department's Perspective*, Legal, Medical and Governmental Perspectives on AIDS as a Disability 16, 17 (1987).

The significance of the ADA Senate Report reference to the Kmiec Memorandum is not entirely clear. To the extent it signifies the Committee's belief that asymptomatic HIV is always a disability, it contradicts the Committee's simultaneous endorsement of the HUD approach, which specifically recognizes HIV as a physical impairment, but not a handicap per se.

This pattern of conflicting HUD and Kmiec Memorandum endorsements repeats itself in the ADA House Education and Labor Committee and Judiciary Committee Reports. For example, two pages after endorsing the HUD analysis, the House Education and Labor Committee Report states: "As noted by the U.S. Department of Justice, 'Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals,' September 27, 1988, at 9-11, a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." H. Rep. No. 101-485(II), 101st Cong., 2d Sess. 52, 1990 U.S.C.C.A.N. 303, 334.[16] Statements by several individual members of the House and Senate on the floor of Congress also seem to treat HIV as a disability per se.[17]

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[16] *See also* H. Rep. No. 101-485(III), 101st Cong., 2d Sess. 29 n.18, *reprinted in* 1990 U.S.C.C.A.N. 445, 451.

[17] *E.g.*, 136 Cong. Rec. H4621 (July 12, 1990) (Rep. Dannemeyer) ("The American people have no idea that with the adoption of this act we are instantaneously going to bring within the definition of disabled person across this land every HIV carrier in America"); *id.* at H4626 (Rep. Waxman) ("All such individuals [from asymptomatic HIV infection, to symptomatic HIV infection] are covered under the first prong of the definition of disability in the ADA."); *id.* at S9694 (July

What should the Court make of these conflicting signals in the legislative history?

One answer is nothing. The wording of the definition is plain there are no "per se" disabilities. There is no justification for relying on the legislative history.

However, even if the statute were in pertinent part ambiguous, there is still no solution in the legislative history. This is because the relevant history is seriously conflicting, so that to rely on one part (e.g., endorsements of the Kmiec Memorandum) to the exclusion of another (e.g., endorsements of the HUD approach) would be like "'looking over a crowd and picking out your friends.'" Patricia M. Wald, *Some Observations on the Use of Legislative History in the 1981 Supreme Court Term*, 68 Iowa L. Rev. 195, 214 (1983) (quoting Judge Leventhal); *see Atherton v. FDIC*, ___ U.S. ___, ___, 117 S.Ct. 666, 676 (1997) (O'Connor, J., concurring) (joining in the Court's opinion "except to the extent that it relies on the notably unhelpful legislative history" that is "as the majority recognizes, 'not all on one side.'"); *Public Citizen v. Department of Justice*, 491 U.S. 440, 471 (1989) (Kennedy, J., concurring) (improper to disregard plain language on the basis of "fairly confident" reading of legislative history).

Ms. Abbott may argue that the numerous endorsements of the HUD regulations in the

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13, 1990) (Sen. Armstrong) ("the legislative history of this bill makes clear that infection with the AIDS virus—even in the absence of any disabling symptoms—is a covered disability").

Committee reports do not create a serious conflict because of the numerous, more explicit references, supporting the view that HIV is a per se disability. This argument is blatantly "picking out your friends." More fundamentally, it fails to appreciate how important committee reports get drafted on politically controversial issues.

On politically controversial issues, legislators' staff members carefully review report language, "suggesting changes, and negotiating compromises." Stephen Breyer, *On the Uses of Legislative History in Interpreting Statutes*, 65 S. Cal. L. Rev. 845, 857 (1992). In this instance, for "three weeks Democratic and Republican Senate staff worked intensely with the administration, the disability community, and the business community to develop [the ADA Senate Report] that established an accurate historical record reflecting the *various negotiated agreements*." National Council on Disability, *Equality of Opportunity--The Making of the Americans with Disabilities Act* 120 (1997) (emphasis added).

It is therefore virtually certain that the drafters of the ADA Senate Report, which is the model for the ADA House Reports, understood perfectly that the HUD regulations they were citing, 54 Fed. Reg. 3232, 3245, do not deem HIV a per se handicap. Thus, the most plausible explanation for the inconsistency in the ADA Committee Reports is that the negotiated political price for including statements that asymptomatic HIV is a disability, was express endorsements of the HUD regulations

issued six months earlier, which treat HIV as an impairment and not a disability.[18]

We will never know if this is what happened. Deposition of those who drafted the ADA Senate Report, even if permitted, would likely substitute disagreement over historical fact for surmise over conflicting language.

What is clear concerning the decision whether HIV is a per se disability is that a move from reliance on the statute to reliance on legislative history is a move from what is arguably plain and in accord with common sense (that a person with HIV is actually disabled only if she demonstrates she is substantially limited in a major life activity), to what is less plain and logically unsupportable (that all asymptomatic persons with HIV are substantially limited in a major life activity).[19] The Court should therefore decline the invitation to

[18] The ADA Senate Report further states that the Presidential Commission on HIV recommended that all "persons with symptomatic or asymptomatic HIV infection should be *clearly included* as persons with disabilities." S. Rep. 101-116, 101st Cong., 1st Sess. 19 (emphasis added). Congress rejected this recommendation. HIV infection is nowhere mentioned in the legislation passed after extensive debate. So visible was this issue that it is unreasonable to attribute the omission to a drafting error. The more likely explanation is that the ADA would not have passed if it contained a special provision that all asymptomatic persons with HIV are disabled.

[19] Exhibit B of the American Dental Association's *amicus* brief for the Appeals Court is a copy of an April 12, 1996, letter from four senators who supported the ADA, *see* 136 Cong. Rec. S9695, and who now favor a policy of "retaining *non-disabled* HIV-positive service members" (emphasis added). This shows that even Senators who supported the ADA do not believe that all persons with HIV are disabled.

elevate parts of the legislative history which treat HIV as a disability per se to the status of the statute. *Cf.* John F. Manning, *Textualism As a Nondelegation Doctrine*, 97 Colum. L. Rev. 673 (1997); Note, *Why Learned Hand Would Never Consult Legislative History Today*, 105 Harv. L. Rev. 1005 (1992).[20]

III. SEXUAL INTERCOURSE AND REPRODUCTION ARE NOT MAJOR LIFE ACTIVITIES ENVISIONED BY THE ADA.

A. The Theory That Sexual Intercourse and Reproduction Are Major Life Activities Is Contrary to the Focus and Purpose of the ADA.

The Court has "[o]ver and over . . . stressed that '[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.'" *United States Nat'l Bank of Or. v. Independent Ins. Agents of N. America, Inc.*, 508 U.S. 439, 455 (1993) (quoting *United States v. Heirs of Boisdore*, 8 How. 113, 122 (1849)); *see Securities and Exchange Comm'n v. C. M. Joiner Leasing Corp.*, 320 U.S. 344, 350-51 (1943) ("courts will construe the details of an act in conformity with its dominating general purpose").

[20] If scientists had found a cure for AIDS four weeks after passage of the ADA, or find a cure four weeks from today, what sense would it make to treat HIV as an actual disability based on legislative history? A finding of disability under the ADA will always require an individualized inquiry into whether a plaintiff satisfies any of the three prongs of the definition.

The ADA states that its goal is to provide a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," and to provide "clear, strong, consistent, enforceable standards addressing [such] discrimination." 42 U.S.C. § 12101(b)(1) & (2). The ADA Senate Report and all House Reports further provide that the purpose of the ADA is to "to bring persons with disabilities into the economic and social mainstream of American life." S. Rep. 101-116, 101st Cong., 1st Sess. 2.[21]

The ADA finds that discrimination denies persons with disabilities "the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity"; that people with disabilities are "severely disadvantaged socially, vocationally, economically, and educationally"; and that individuals with disabilities continually encounter discriminatory effects of "architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing

[21] *See* H. Rep. 101-485(I), 101st Cong., 2d Sess. 24, *reprinted in* 1990 U.S.C.C.A.N. 267, 268 (the ADA "will permit the United States . . . to welcome individuals with disabilities fully into the mainstream of American society"); H. Rep. 101-485(II), 101st Cong., 2d Sess. 22, *reprinted in* 1990 U.S.C.C.A.N. 303, 304 (the purpose of the ADA is "to bring persons with disabilities into the economic and social mainstream of American life"); H. Rep. 101-485(III), 101st Cong., 2d Sess. 23, *reprinted in* 1990 U.S.C.C.A.N. 445, 446 (same); H. Rep. 101-485(IV), 101st Cong., 2d Sess. 23, *reprinted in* 1990 U.S.C.C.A.N. 512, 512 (same).

facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities." 42 U.S.C. § 12101(a)(5),(6), and (9).

These purposes and findings are broad, but when they are read in context no unbiased reader would think Congress was contemplating the obstacles faced by persons suffering from reproductive disorders, such as impotence and infertility.[22] The Appeals Court's amorphous concept of "[r]eproduction (and the bundle of activities it encompasses)" (Pet. App. 11a) is also antithetical to the ADA's intent to provide "*clear* . . . enforceable standards." 42 U.S.C. § 12101(b)(2) (emphasis added).

The list of privately owned public accommodations subject to title III includes hotels, restaurants, bars, other establishments serving

[22] Impotence, also called erectile disorders, refers to a male's inability to attain or maintain penile erection sufficient to complete intercourse. *See Professional Guide to Diseases* 1004 (5th ed. 1995). Causes of male infertility include semen disorders, abnormal sperm, trauma to testes, and endocrine imbalances. *Id.* at 1010-1011. Causes of female infertility include anovulation and uterine abnormalities. *Id.* at 932-33. Impotence and infertility are to genital intercourse and reproduction as blindness is to seeing: namely, if sexual intercourse and reproduction are major life activities under the ADA, then impotence and infertility are as clear examples of actual disability as total blindness. Likewise, if an asymptomatic HIV-infected woman is disabled because of limits on her ability to have sex and reproduce, when she is able to have sex and reproduce, then impotent and infertile persons, who are actually unable to have sex and reproduce, are obviously disabled.

food and drink, motion picture houses, stadiums, lecture halls, other places of public gathering, bakeries, grocery stores, clothing stores, other sales establishments, laundromats, gas stations, travel services, shoe repair services, other service establishments, terminals, other stations used for public transportation, museums, libraries, parks, other places of recreation, schools, senior citizen centers, gymnasiums, golf courses and other places of exercise and recreation. 42 U.S.C. § 12181(7).

This lengthy list of places *is* the "mainstream of American life" into which title III wants to bring persons with disabilities. It is difficult to imagine how it would have been intended that persons with reproductive disorders needed protection to get them into this mainstream, when they have no special difficulty in going to restaurants, clothing stores, gas stations, libraries, bowling alleys, and so forth.[23] Also telling is that nowhere in the ADA's long legislative history does anyone refer to persons with reproductive disorders as a class of individuals deprived of economic and social

[23] The term "auxiliary aids and services" for use in all five titles of the ADA is defined as "qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments," "qualified readers, taped texts, or other effective methods of making visually delivered materials available to individuals with visual impairments," "acquisition or modification of equipment or devices," and "other *similar* services and actions." 42 U.S.C. § 12102(1) (emphasis added). Such aids and services have no obvious application as applied to persons with reproductive disorders.

integration into public life, and therefore covered by the ADA.[24]

The purpose of title III of the ADA, therefore, is not to facilitate sexual activity, to encourage pregnancy, or to prevent discrimination based on an inability to have sex or reproduce.[25] The purpose is to bring persons into the mainstream of American economic and civic life. Congress simply did not envision impotence and infertility, or the decision not to engage in intimate sexual relations or to raise a family, as physical or mental disabilities under the ADA.[26]

[24] Typical is the statement that the ADA is about "the 2 million Americans with mental retardation, the 15.5 million Americans with severe physical functional limitations, or the 24 million Americans with speech, language, or hearing disabilities, those with spinal cord injuries, those with head injuries, those who are blind and deaf or who have multiple sclerosis, or muscular dystrophy, or cerebral palsy." 136 Cong. Rec. H4615-H4616 (Rep. Bartlett) (July 12, 1990).

[25] The Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k), prohibits discrimination based on pregnancy, on the potential to become pregnant, *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 198 (1991), and on the inability to become pregnant, *Erickson v. Board of Govs. Of State Colleges and Univs. for N.E. Ill. Univ.*, 911 F. Supp. 316, 320 (N.D. Ill. 1995).

[26] The ADA excludes from the definition of disability "compulsive gambling, kleptomania, or pyromania" and "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders." 42 U.S.C. § 12211(b). Ms. Abbott may argue these exclusions imply Congress' underlying assumption that sex and reproduction are major life activities for defining disability. Rather than implying anything about Congress' reasoned analysis of the three-prong definition of disability, this list more likely evinces Congress' lack of concern for the specifics of the definition, confusion as between impairments and

B. The Theory That Sexual Intercourse and Reproduction Are Major Life Activities for Defining Disability Is Contrary to the Meaning of Disability in Influential Documents Presented to Congress to Promote Passage of the ADA and Other Contemporaneous, Influential Studies Of Disability in America.

The House Conference Report on the ADA explains that the National Council on Disability (formerly the National Council on the Handicapped) was "the impetus, force, and originator of the initial legislation for the [ADA], reflected in the Council's report, 'Toward Independence,' published in February, 1986." H. Conf. Rep. 101-596, 101st Cong., 2d Sess. 85, *reprinted in* 1990 U.S.C.C.A.N. 565, 594.

The Council's report *Toward Independence* contains a section called "The Population with Disabilities." That section examines surveys and estimates of the total disabled American population, citing examples and categories such as recent heart by-pass surgery, cerebral palsy, severe depression, blindness, spinal cord injuries, speech and hearing impairments. There are no examples or categories corresponding to those with specifically reproductive disorders. National Council on the Handicapped, *Toward Independence* 3-6 (Feb. 1986).[27] The Council's follow-up report

disabilities, and above all else, an absolute political desire to exclude certain classes of people no matter what the definition may be.

[27] A category such as "partially or completely paralyzed," *id.* at 6, includes people who cannot reproduce, but this is not a category corresponding to specifically reproductive disorders.

to Congress also examines surveys and estimates of the total disabled American population and likewise includes no examples or categories corresponding to those with specifically reproductive disorders. National Council on the Handicapped, *On the Threshold of Independence* 9-17 (Jan. 1988). Likewise, neither *Americans With Disabilities: 1991-1992* (Bureau of the Census 1993), nor *Disability In America* (National Academy Press 1991), include references or categories corresponding to persons with specifically reproductive disorders.[28]

C. The Regulatory History of the ADA, and Other Factors, Show That the ADA Does Not Contemplate Sexual Intercourse and Reproduction As Major Life Activities.

Neither sex nor reproduction is included in the Justice Department's regulatory list of major life activities. 28 C.F.R. § 36.104. This is not dispositive because the list does not purport to be exclusive. In light of the rule's history, however, their absence is so conspicuous that the Court should interpret the list as a reasonable conclusion by the Justice Department that "disability" under title III of the ADA should not be defined in terms of limits on specifically sexual or reproductive activity.

[28] The latter reports that "major activities" for defining disability in the 1988 National Health Interview Survey were "playing" for young children, "attending school" for older children, "working" or "keeping house" for adults, and "living independently" for senior citizens. *Id.* at 42.

More precisely, the Justice Department was familiar with the Kmiec Memorandum and the question of HIV as a disability. In its regulatory preamble the Department refers to both and follows HUD's lead by including "asymptomatic HIV disease" as one example of a physical impairment, but not a per se disability. 56 Fed. Reg. 35544, 35548 (July 26, 1991), *reprinted at* 28 C.F.R. Pt. 36, App. B § 104. On the next page, *id.* at 35549, the Department presents and explains its list of major life activities, but does not include reproduction, or a single one of the bundle of reproductive activities (intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations) named by the Appeals Court.

Obviously activities such as having sex, giving birth, changing diapers, and loving and educating one's children are activities of paramount importance to many Americans and in that sense are major life activities. This, in fact, is the Appeals Court's rationale for ruling that reproduction is a major life activity under the ADA. But it makes no sense, given the controversy surrounding HIV as a disability, the Kmiec Memorandum's reference to HIV-infected persons as substantially limited in the major life activities of "procreation and intimate personal relations," and the fact that reproductive activities are unmistakably part of everyday life for so many people (as Ms. Abbott will argue, the *sine qua non* of life itself), that the Justice Department would have meant to include sex and reproduction on its list of exemplar major life activities, but forgot or thought it was not worthy of explicit clarification.

Furthermore, the Justice Department's list of major life activities is taken verbatim from a list first formulated in regulations issued by HEW under the Rehabilitation Act, 42 Fed. Reg. 22676, 22678 (May 4, 1977). These regulations "were drafted with the oversight and approval of Congress." *Arline*, 480 U.S. at 279-80; *see Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 634 (1984). Ms. Abbott would have the Court conclude that although reproductive activities are the most fundamental of all life activities, and although Congress and federal agencies envisioned them as major life activities for defining "disability" under the Rehabilitation Act and the ADA, Congress, HEW, HUD, EEOC, and the Justice Department, after analyzing thousands of comments and participating in over twenty different hearings, all forgot to include reproductive activities in their respective lists of exemplar major life activities.

The more sensible conclusion for the Court is the obvious one: Although reproductive activities are of paramount importance in many persons' private, family lives, such activities are not what Congress envisioned as major life activities for defining disability under title III of the ADA, the goal of which is to integrate persons with disabilities into the mainstream of American civic life.[29]

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[29] Similar reasoning applies to "caring for others," or what the Appeals Court called "nurturing familial relations." (Pet. App. 7a). "Caring for one's self" has appeared on regulatory lists of exemplar major life activities since 1977, and any person reviewing such a list would have had to have considered

Including sexual intercourse and reproduction as major life activities for defining disability under the ADA also leads to some serious interpretive problems. For example, are post-menopausal women disabled? If not, is a post-menopausal woman who becomes infected with HIV disabled because of an inability to reproduce? Do we really think, or is it wise to think, that infertile women are disabled, or does this reinforce cultural stereotypes the ADA seeks to avoid? And what, really, does "reproduction" refer to? Does the Appeals Court really mean to suggest that sexual intercourse for the sake of procreation is a major life activity, because it is part of the bundle of reproductive activities, whereas sexual intercourse using a condom is not? Are men and women who undergo voluntary sterilization for family planning purposes "disabled"? A person who intentionally blinds himself is just as disabled as one who was accidentally blinded. So why would a person who was voluntarily sterilized not be disabled?

Some of these questions illustrate the important fact that reproductive activities, for human beings, are largely moral and lifestyle choices, in contrast to walking, seeing, hearing, speaking, and breathing. Many normal healthy adults choose not to have children, but they do not poke their eyes out. This fundamental dissimilarity has led the Eighth Circuit to the sensible conclusion that reproduction is not a major life activity for purposes of the ADA. *Krauel*

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whether "caring for others" should be on the list as well. The only reasonable conclusion is that several federal agencies decided it does not belong.

v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996); *see also Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995) (unlike other activities on the regulatory list, a person is not "called upon to reproduce throughout the day, every day," and treating reproduction as a major life activity under the ADA "would be a conscious expansion of the law . . . beyond the province of this Court"), *aff'd*, 79 F.3d 1143 (5th Cir. 1996).

An obvious retort is that "working" and "learning" are lifestyle choices for some, but they are major life activities under the ADA. These are easily distinguishable, however, in light of the manifest purposes of the ADA. The purpose of title I of the ADA is to promote gainful employment among the disabled, wherever reasonable, and one important purpose of title III is to expand private educational opportunities for the disabled, especially the mentally retarded, *see* 42 U.S.C. § 12181(7)(J). No similar purpose of title III warrants the inclusion of sex and reproduction as major life activities.

The Appeals Court cites *Stanley v. Illinois*, 405 U.S. 645 (1972), to illustrate the importance of reproductive activities in our society, and says that "our jurisprudence reflects this bias." (Pet. App. 7a) The Appeals Court is wrong to imply a judicial bias favoring reproduction, for our jurisprudence also supports the right *not* to reproduce. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Griswold v. Connecticut*, 381 U.S. 479 (1965).[30]

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[30] *Cf. Runnebaum*, 123 F.3d at 171 n.8 (agreeing that procreation is a fundamental human activity, skeptical that it

Ms. Abbott will also rely on the statement in a House Committee Report that "[a]s noted by the [Kmiec Memorandum], a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to *procreation and intimate sexual relationships.*" H. Rep. 101-485(II), 101st Cong., 2d Sess. 52, *reprinted in* 1990 U.S.C.C.A.N. 303, 334 (emphasis added).

This is the only manner in which the ADA's legislative history treats limitations on procreation and intimate sexual relationships as defining marks of disability. The reason such a statement appears in the Committee Report has nothing to do with addressing the concerns of impotent and infertile persons. The reason it is there is because of the controversy surrounding HIV as a disability. The words "procreation and intimate sexual relationships" appear in the legislative history *only* because they are part of the Kmiec Memorandum's unsupportable argument that all HIV-infected persons are actually disabled. For reasons previously stated, *supra* part II, pp. 19-27, the Court should not elevate such legislative history to the status of the statute on whether HIV is a per se disability. *Ipso facto* the Court should not give such history deciding weight on a different issue to which it is not even directed, namely, whether

is a major life activity contemplated by the ADA, and noting that the constitutionally protected status of an activity has little, if any, bearing on whether it is a major life activity contemplated by the ADA).

sexual activity and reproduction are major life activities generally.[31]

The basic dissimilarity between reproduction and the activities on agencies' illustrative lists of major life activities, Congressional approval of these lists, the meaning and examples of "disability" found in influential reports to Congress, and the purpose of title III of the ADA, which is to integrate persons with disabilities into the mainstream of American life, all lead to the conclusion that title III of the ADA does not envision sexual activity and reproduction as major life activities for the purpose of defining disability.

IV. EVEN IF REPRODUCTION WERE A MAJOR LIFE ACTIVITY UNDER THE ADA, AN ASYMPTOMATIC HIV-INFECTED WOMAN'S DECISION NOT TO REPRODUCE DOES NOT MAKE HER DISABLED.

Many asymptomatic women with HIV decide to become pregnant and have children, and most of their children are not infected with HIV. Many

[31] On related issues concerning the definition of disability, courts have ignored statements in the same Committee Report that are inconsistent with the plain language of the ADA. For example, the Report treats diabetes as a per se disability, and states that disability should be assessed without regard to medication. H. Rep. No. 101-485(II), 101st Cong., 2d Sess. 52 *reprinted in* 1990 U.S.C.C.A.N. 303, 334; *but see Wilking v. County of Ramsey*, ___ F. Supp. ___, ___, 1997 WL 694968, *3-*4 (D. Minn. 1997) (considering limitations in light of medication and citing cases); *Schluter v. Industrial Coils, Inc.*, 928 F. Supp. 1437, 1445 (W.D. Wis. 1996) (diabetes not a per se disability); *Deckert v. City of Ulysses*, 1995 WL 580074 (D. Kan. 1995) (same).

asymptomatic women with HIV decide not to have children. The difference between them is not physical, but decisions made according to their respective moral, religious, and cultural values. Physically, there is no substantial limitation on their abilities to reproduce, and therefore no disability under 42 U.S.C. § 12102(2)(A), which defines disability as a physical impairment (e.g., a spinal cord injury) that substantially limits a major life activity (e.g., walking). *See Runnebaum*, 123 F.3d at 172 (the "statutory language is plain: the impairment in question, not the individual's reaction to the impairment, must 'substantially limit[] one or more . . . major life activities").

Ms. Abbott may reply that HIV is an impairment that substantially limits reproduction in women who could have children, but decide not to, even if the link is psychological or moral, rather than physical. According to this argument, a link is no less real because it is psychological. One problem with this view is that physically identical people turn out to differ as to actual disability, which seems absurd. Another problem is that actual disability becomes a matter about which a woman can simply change her mind. That, too, seems absurd, compared to the view that actual disability is a lasting physical or mental phenomenon. *Cf.* 42 U.S.C. § 12101(a)(7) (disabling characteristics are "beyond the control" of persons with disabilities).

Another reply is that *all* asymptomatic women with HIV are substantially limited in the ability to reproduce, even those who have and care for healthy children, because all confront the risk of

perinatal transmission and their own uncertain life expectancies. This, however, empties the concept of "actual disability" of whatever meaning it had left. Women in abject poverty or violent neighborhoods confront in their reproductive decision-making risks just as significant that they and their babies will live short and miserable lives. Are they too actually disabled?[32] The more sensible view is that although many asymptomatic women with HIV decide not to have children because of significant risks and uncertainties, that does not make them actually disabled for purposes of the ADA.

V. EVEN IF REPRODUCTION WERE A MAJOR LIFE ACTIVITY, DR. BRAGDON CANNOT BE LIABLE IF THE REASON MS. ABBOTT IS DISABLED IS BECAUSE OF LIMITS ON HER ABILITY TO REPRODUCE.

Under title I of the ADA, an employer must know of an employee's disability for liability to attach. *E.g., Hedberg v. Indiana Bell Tel. Co., Inc.*, 47 F.3d 928, 932 (7th Cir. 1995). The same rule should apply under title III for private owners of public accommodations.

When Dr. Bragdon declined to fill Ms. Abbott's cavity in his office, he did not know Ms. Abbott's views about having children, e.g., whether she decided not to have children before she became

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[32] With advances in genetic science, more people will be identified who are carriers of defective genes that put them and their would-be offspring at risk for various disorders. Carriers of such genes are presently at risk for developing a disability, but they are not actually disabled.

infected, whether she still planned to have children, whether she decided not to have children after becoming infected, or whether she was physically infertile. Nor did her reproductive decision-making play any role in his decision-making. Thus, if Ms. Abbott's decision not to have children, rather than her HIV status alone, is the reason she is disabled, Dr. Bragdon cannot be liable under title III for discriminating against her "on the basis of disability." 42 U.S.C. § 12182(a).

VI. COURTS SHOULD DEFER TO PRIVATE HEALTH CARE PROVIDERS' INDIVIDUAL JUDGMENTS ABOUT DIRECT THREAT, AS LONG AS THEY ARE REASONABLE IN LIGHT OF THEN-CURRENT MEDICAL KNOWLEDGE.

A health care provider is not required by law to provide services to an individual who poses a direct threat to the health of others, including the health care provider. 42 U.S.C. § 12182(b)(3).[33] The words in the statute and its legislative history make clear that Congress intended to incorporate the direct threat standard from *Arline*. *E.g.*, H. Rep. No. 101-485(III), 101st Cong., 2d Sess. 34, 62 *reprinted in* 1990 U.S.C.C.A.N. 445, 457, 485. The Justice Department regulations effectuate this intent by specifying that in determining whether an individual poses a direct threat, a health care provider must make "an individualized assessment, based on *reasonable* judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the

[33] Many believe that Dr. Bragdon acted ethically, but many who do not would agree that liberal democracy depends on a distinction between moral and legal obligations.

nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk." 28 C.F.R. § 36.208(c) (emphasis added).

Based on the regulation's plain language, the lower courts should have inquired only as to whether, on September 16, 1994, Dr. Bragdon made a reasonable judgment based on then-current medical knowledge and pertinent individualized facts, that there would have been a direct threat to himself and/or others if he filled Ms. Abbott's cavity in his office. If Dr. Bragdon's judgment was reasonable, then regardless of what moral philosophers may say, or what was implicit (or even explicit) in conflicting private or public health guidelines, he had no legal obligation under title III of the ADA to fill the cavity in his office. This view comports with legislative history which states that "nothing in this legislation is intended to prohibit a physician from providing the most appropriate medical treatment *in the physician's judgment*." S. Rep. 101-116, 101st Cong., 1st Sess. 63 (1989) (emphasis added); *cf. Onishea v. Hopper*, 126 F.3d 1323, 1330 (11th Cir. 1997) (burden is on plaintiffs under § 504 to show that HIV infection poses no significant risk to others); *E.E.O.C. v. Amego, Inc.*, 110 F.3d 143 (1st Cir. 1997) (burden is on plaintiffs under title I to show they do not pose a significant risk to others).

The lower courts, however, injected a new policy twist into the analysis, based mostly on *Arline's* words that "courts normally should defer to the reasonable medical judgments of public

health officials." *Arline*, 480 U.S. at 288. For the District Court this meant Dr. Bragdon had to prove at summary judgment that a CDC official's after-the-fact affidavits were "medically unsupportable." For the Appeals Court this meant Dr. Bragdon had to overcome at summary judgment a presumption of the correctness of what "seemed implicit" in 1993 CDC Guidelines.

Arline, however, specifically states that it does not address whether courts should defer to reasonable medical judgments of private physicians. *Arline*, 480 U.S. at 288 n.18; *see Kohl by Kohl v. Woodhaven Learning Ctr.*, 865 F.2d 930, 938 (8th Cir. 1989), *cert. denied*, 493 U.S. 892 (1989). Indeed, the American Medical Association (AMA) *amicus* brief relied upon by the Court in *Arline*, 480 U.S. at 288, argues that federal courts "should not choose between conflicting medical judgments offered by plaintiff and defendant, if defendant recipient[] can demonstrate that the medical evidence upon which he relied was within the range of reasonableness, given then current medical knowledge." AMA Brief 20 n.16 (No. 85-1277)

There are good reasons why the Court should follow this advice from the AMA concerning deference to private professional judgments within a range of reasonableness given then-current medical knowledge.

First, as already indicated, the regulations and legislative history appear to require it.

Second, in a variety of contexts, the Court has applied a standard of review based on deference to reasonable professional judgment. For example, in *Youngberg v. Romeo*, 457 U.S. 307 (1982), the Court held that the exercise of professional judgment set the proper standard for determining whether a State had adequately protected the rights of an institutionalized mentally retarded person to safety and freedom from unreasonable restraint. In determining what is "reasonable" in this situation, "courts must show deference to the judgment exercised by a qualified professional." *Id.* at 322. Applying this standard, the court's responsibility is to make certain that professional judgment was in fact exercised, but "it is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id.* at 321.[34]

With respect to a student's property interest in continued enrollment, the Court again emphasized the importance of showing respect for professional judgment, and stated that the Court would not override the faculty's professional judgment "unless it is such a substantial departure from accepted academic norms as to demonstrate that the person or committee did not actually exercise professional judgment." *Regents of the University of Michigan v. Ewing*, 474 US 214, 225 (1985).[35]

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[34] The AMA's Principle VI of Medical Ethics is that a "physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." AMA, *Code of Medical Ethics* (1997).

[35] In reviewing a claim of ineffective assistance of counsel, the Court has stated that "judicial scrutiny of counsel's

In cases recognizing and confirming a woman's right to terminate a pregnancy, the Court has also recognized the importance of individual medical decisions and given deference to a physician's exercise of professional judgment. In *Roe v. Wade*, 410 U.S. 113, 163-65 (1972), the Court ruled that prior to the time when the state has a compelling interest in the pregnancy, the physician's medical judgment may be effectuated "free of interference from the State," and after that point, the state's interest may still be overridden by "appropriate medical judgment." In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 64-65 (1976), the Court observed that determination of viability should not be a function of the legislature or the courts but "rests with the physician in the exercise of his professional judgment." *Colautti v. Franklin*, 439 U.S. 379, 387-88 (1979), reaffirmed the role of professional judgment, based on the particular facts of each case, and repeated the "importance of affording the physician adequate discretion in the exercise of his medical judgment."[36]

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performance must be highly deferential," and the claimant must identify actions "that are alleged not to have been the result of reasonable professional judgment." *Strickland v. Washington*, 466 U.S. 668, 690 (1984); *see also Washington v. Harper*, 494 US 210, 232 (1990); *Goldman v. Weinberger*, 475 U.S. 503, 507 (1986).

[36] *See also United States v. Massachusetts*, 890 F.2d 507, 510 (1st Cir. 1989) ("The principle that, in cases where expertise is required, qualified professionals must be free to exercise their judgment within constitutional confines is firmly rooted in our jurisprudence."); *cf.* Susan M. Miltko, *The Need For Professional Discretion: Health Professionals Under the [ADA]*, 89 Nw. U. L. Rev. 1731 (1995).

Third, deference to government health officials is based on an ahistorical, doubtful assumption, that they, rather than private doctors are more likely right. It is less important in this regard to recall the specifics of *Buck v. Bell*, 274 U.S. 200 (1927), than the fact that what happened *seemed* right at the time to well-meaning intelligent members of the Court and public health authorities. The short-lived swine flu immunization program of 1976 is another illustration of the questionable assumption that government health officials are presumably correct.[37]

This does not mean private citizens are more often correct. It is only to remind the Court that when searching for what is right, it will often be comfortable to defer to well-meaning public officials. Historically, however, there is scant

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[37] The swine flu vaccine recommended by CDC had the unanticipated serious side-effect of significantly increasing the risk of developing Guillain-Barre syndrome (a sometimes fatal, ascending paralysis). Richard Neustadt & Harvey Fineberg, *The Swine Flu Affair* 73 (1978) (study published and commissioned by HEW); Arthur Silverstein, *Pure Politics & Impure Science: The Swine Flu Affair* 116-122 (1981). The risk of developing Guillain-Barre syndrome for vaccinees was still less than 1 in 100,000, but public health officials deemed this unacceptably high (i.e., very significant) in light of the unanticipated absence of swine flu among those not inoculated. The mass inoculation program was therefore abandoned. Neustadt & Fineberg, *supra*, at 1, 69-73; Silverstein, *supra*, 118-119. The HEW study blamed the fiasco on, *inter alia*, "overconfidence by specialists in theories spun from meagre evidence" and "conviction fueled by a conjunction of some preexisting personal agendas." Neustadt & Fineberg, *supra*, at 1.

justification for believing that this more often leads to what is right, and depending on who is in power, it can be positively dangerous. The safer and wiser thing to do is for courts to treat the opinions of government health officials like the opinions of other experts: neither presumably correct nor incorrect, but subject to vigorous cross-examination and presentation of contrary evidence according to the conventional devices of our adversary system. *Cf. Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 596 (1993) (rejecting "general acceptance" test for admissibility of scientific evidence and relying upon the ordinary tenets of the adversarial process); *Davis v. Meese*, 692 F. Supp. 505, 520 (E.D. Pa. 1988) (weighing competing expert opinions as to risk in § 504 case), *aff'd*, 865 F.2d 592 (3rd Cir. 1989) (per curiam).

Fourth, special deference to public health officials in litigation under title III is based on a misunderstanding of public health authority expertise, which is to study and make recommendations for *populations* not *individuals*. Their analyses subsume, rather than manifest, the particular facts according to which reasonable professional judgments must be made. In any given case, such facts may include the fact that this dentist is more clumsy and cuts himself more often, the fact that this cavity will require more and difficult drilling, or the fact that this patient is new and jittery.

Imagine a private physician in 1976 who decided not to take a swine flu shot because the vaccine had not been adequately tested, in his judgment. Should Congress have passed a law

compelling every person to take a shot unless he or she could overcome in court a presumption that CDC was correct in its initial analysis? One would think there would be a great deal of public debate preceding such legislation, and that courts would not easily imply such a rule where none was express. Yet, the District Court and Appeals Court did not hesitate to find implicit in the ADA a Congressional intent to compel dentists to take identifiable occupational risks, based on dimly articulated CDC policy analysis, even if individual professionals may reasonably believe such risks are significant.

Fifth, deference to public health officials is difficult when they disagree, which is not uncommon.[38] In this case, reasonable conflicting inferences may be drawn from OSHA, FDA, and CDC sources. (Pet. 13-17) In addition, is a school nurse entitled to the same degree of deference as OSHA regulations? Are private physicians who serve on advisory committees for public health organizations entitled to speak as public health officials? The more workable solution is to rely on the conventional devices of the adversarial system rather than *a priori* categories and presumptions.

Persons with disabilities should reasonably expect service unimpeded by false stereotypes and unfounded fears. When experts disagree as to the significance of the risk to dentists of providing a

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[38] *See, e.g.*, David Brown, *Institute Revises Advice On Mammograms in 40s*, Wash. Post, March 28, 1997, at A1 (reporting divergent views on regular mammograms for women in their forties); Neustadt & Fineberg, *supra* n.33, at 38-39.

service, but there is an identifiable risk which a reasonable dentist could deem personally significant, the law should not compel every qualified dentist to provide the service. Here is the space for civil liberty among dentists. Some will provide the service, some will not, and some will offer to do so with special precautions. Minimum CDC guidelines should not become maximum allowable precautions, and health care workers should not be discouraged from deferring non-emergency treatment to settings where maximum precautions may be taken.

CONCLUSION

WHEREFORE, the judgment of the Appeals Court should be reversed. The case should be remanded for entry of judgment in favor of Dr. Bragdon, or for further proceedings consistent with the opinion of the Court.

Respectfully submitted,

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER, Ph.D.
RUDMAN & WINCHELL, LLC
Attorneys for Petitioner
84 Harlow Street
Bangor, Maine 04401
(207) 947-4501

APPENDIX

42 U.S.C. § 12102(2): "The term 'disability' means, with respect to an individual – (A) a physical or mental impairment that substantially limits one or more major life activities; (B) a record of such an impairment; or (C) being regarded as having such an impairment.

28 C.F.R. § 36.104: "The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

42 U.S.C. § 12182(b)(3): "**Specific Construction**. Nothing in this subchapter [title III of the ADA] shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."

28 C.F.R. § 36.208(c): "In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability

duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk."

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No. 97-156

In The

Supreme Court of the United States

October Term, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, et al.,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The First Circuit

BRIEF FOR THE RESPONDENT MAINE HUMAN RIGHTS COMMISSION

JOHN E. CARNES
Commission Counsel, MHRC
Counsel of Record
Attorney for Respondent
Maine Human Rights Commission
51 State House Station
Augusta, Maine 04333-0051
Tel. (207) 624-6051

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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STATEMENT

In addition to her claim under the Americans with Disabilities Act ("ADA"), Ms. Abbott filed suit alleging a violation of the Maine Human Rights Act ("MHRA"), 5 M.R.S.A. §4551, *et seq.* The Maine Human Rights Commission ("MHRC") was permitted to intervene as a party plaintiff by the district court. The MHRC is the state governmental agency which administers and enforces the MHRA. 5 M.R.S.A. §§4611-4613. The First Circuit held in this case, as did the district court, that interpretation of the ADA and the MHRA proceeds "hand in hand" because they are analogous statutes.[1] Accordingly, Respondent MHRC joins in the Argument presented in the Brief for Respondent Abbott addressing all three questions before the Court. Without unnecessarily duplicating argument made in Respondent Abbott's Brief, the MHRC wishes to bring to the Court's attention its vital interest in ensuring that the federal and state statutes prohibiting disability discrimination are vigorously enforced.[2]

---

[1] *Abbott, et al. v. Bragdon*, 107 F.3d 934 (1st Cir. 1997) (Pet. App. 2a, note 1). Both statutes prohibit public accommodations from discriminating on the basis of disability. ADA, 42 U.S.C. §12102(2); MHRA, 5 M.R.S.A. §4592.

[2] The determination of the issues before the Court in this case will significantly affect how state courts around the country interpret the many state discrimination statutes which include a definition of disability similar to that found in the ADA. *See, e.g.*, New Hampshire Law Against Discrimination, Ch. 354-A, N.H.R.S.A. §354-A:2(4) (1992); Vermont Fair Employment Practices Act, 21 V.S.A. §495(d)(5) (1993); Massachusetts Fair Employment Practice Act, Ch. 151B1 Mass. Gen. Laws, §1(17) (1992); Ohio Fair Employment Practice Law,

ARGUMENT

Respondent MHRC joins in the Argument set forth in the Brief for Respondent Abbott addressing all three questions accepted for review by the Court.

In its *amicus* brief to the First Circuit, the Bureau of Health of the Maine Department of Human Services, described its responsibility for controlling infectious diseases, including HIV,[3] and stated its belief that discrimination against people who are infected with HIV impedes its efforts to "stem the tide" of HIV transmission.[4] Discrimination by places of public accommodation and employers based on physical disability has been unlawful in Maine under the MHRA since 1974,[5] and under the

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41 Ohio Revised Code, §4112.01(A)(13) (1992); Colorado Anti-Discrimination Act, 24 C.R.S. §24-34-301(2.5)(a) (1994).

[3] Brief of the *Amici Curiae* Rhode Island Department of Public Health, Department of Public Health of the Commonwealth of Massachusetts, Bureau of Health of the Maine Department of Human Services, American Public Health Association, Association of State and Territorial Dental Directors, and Association of State and Territorial Health Officials, ("Public Health Amici Brief"), p. 1.

[4] *Id.* at 9.

[5] 5 M.R.S.A. §§4571-72 and 4592. The Maine Law Court has expressed the purpose of the MHRA to be the removal of artificial, arbitrary, and unnecessary barriers in order to "guarantee physically [disabled] persons the fullest possible participation in the social and economic life of the State." *Maine Human Rights Commission v. City of South Portland*, 508 A. 2d 948, 954 (Me. 1986), quoting L.D. 2058, Statement of Fact (106th Legis. 1974); *Maine Human Rights Commission v. Canadian Pacific Limited*, 458 A. 2d 1225, 1229 (Me. 1983).

ADA since 1992. The MHRC views the ADA as a powerful tool created by Congress to eliminate the harmful consequences of discrimination against people with physical disabilities.

In its *amicus* brief below, the Maine Bureau of Health noted the fact that people infected with HIV experience widespread discrimination when attempting to obtain dental and other health care services.[6] Specifically, studies have shown that as many as 40% of dentists stated that they would not treat an HIV-positive patient,[7] while 48% of primary care physicians surveyed have said that they will not care for patients infected with HIV.[8] In Maine and other rural states, making unavailable nearly half of health care facilities, or requiring HIV-infected patients to travel to a hospital to have a cavity filled, may often result in considerable hardship because of distance traveled, time away from work and home, and expense. In this case Dr. Bragdon stated that he expected that Ms. Abbott would be required to travel from Bangor, Maine to Machias, Maine, to have her cavity filled, a round trip of more than 100 miles. J.A. 148.

The concern expressed by public health officials is that such discrimination discourages people from getting tested for HIV and deters those who are HIV-positive from seeking needed health care or from disclosing their HIV status to their dentists and doctors. When HIV-infected people avoid the health care system because they

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[6] Public Health Amici Brief, *supra*, at 8.

[7] *Id.*

[8] *Id.* at 8, 9.

fear discrimination, they are denied education and counseling about how to prevent transmission to others.[9] The consequence is that the public health effort to control the HIV epidemic is impeded.

This result is not what Congress intended. In *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), this Court acknowledged the negative effects of society's accumulated myths and fears, prejudiced attitudes and ignorance about contagious disease, then instructed that "courts should normally defer to the reasonable medical judgments of public health officials" when considering the issue of "direct threat." *Arline*, 480 U.S. at 286 n. 15 and 288. The ADA incorporates this requirement. *See*: 28 C.F.R. pt. 36, app. B at p. 600 (1994) (deference must be given to the reasonable medical judgments of "public health officials, specifically public health authorities such as the U.S. Health Service [and] the Centers for Disease Control.") The Centers for Disease Control and Prevention (CDC) have evaluated the current medical evidence concerning risk of transmission of HIV from patient to dentist and concluded that, if universal infection-control practices for dentistry are followed, it is safe to provide routine dental care in the private dental office. *See: 1993 CDC Recommended Infection-Control Practices for Dentistry*, Pet. App. 181a-199a. And, since 1988, it has been the official position of the American Dental Association that "patients with HIV infection may be safely treated in private dental offices where appropriate infection control procedures are employed." American Dental Association *Policy Statement on AIDS-HIV Infection and the Practice of*

[9] *Id.*

Dentistry (1988: 457; 1991: 591), Appeals Court Appendix at 273. By adhering to the directive in *Arline* to defer to the reasonable medical judgments of public health officials such as the CDC, at least in the absence of "contrary properly supported opinions [of] other recognized experts in the field,"[10] the First Circuit found the proper balance intended by the ADA protecting health care providers and patients with HIV infection.

CONCLUSION

For the foregoing reasons and those in Respondent Abbott's Brief, Respondent Maine Human Rights Commission respectfully submits that the decision below should be affirmed.

Dated: February 3, 1998

Respectfully submitted,

JOHN E. CARNES
Counsel of Record
Commission Counsel, MHRC

Attorney for Respondent
Maine Human Rights Commission
51 State House Station
Augusta, ME 04333-0051

Tel. (207) 624-6051

[10] *Abbott, supra*, at Pet. App. 12a.

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BRIEF FOR THE RESPONDENT SIDNEY ABBOTT

BENNETT H. KLEIN
Counsel of Record
GAY & LESBIAN ADVOCATES & DEFENDERS
294 Washington Street
Suite 740
Boston, MA 02108-4608
(617) 426-1350

WENDY E. PARMET
Northeastern University School of Law
400 Huntington Avenue
Boston, MA 02115
(617) 373-2019

Attorneys for Respondent Sidney Abbott

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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QUESTIONS PRESENTED

1. Do all persons infected with the Human Immunodeficiency Virus have a disability under the Americans with Disabilities Act (ADA), either because they have a "physical impairment which substantially limits one or more major life activities," or because they are "regarded as" having such an impairment?

2. Is reproduction a major life activity within the meaning of the ADA?

3. Should courts defer to public health authorities or to non-specialist health care providers, such as a general dentist, in determining whether the risk of transmission of an infectious disease justifies discrimination against a patient under the ADA?

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STATEMENT OF THE CASE

This action was commenced in 1994 under the Americans with Disabilities Act (ADA) to enjoin petitioner Randon Bragdon, a dentist, from refusing to provide routine care to patients, including the respondent, Sidney Abbott, because they have tested positive for the human immunodeficiency virus (HIV). J.A. 143 (No. 11); *see also* J.A. 224, petitioner's written "Infectious Disease Policy."

Infectious, incurable, and virtually always fatal,[1] HIV poses a unique public health challenge. Caused by a retrovirus, HIV progressively destroys the immune system and is the leading cause of illness-related mortality of young adults aged 25-44. J.A. 55, ¶ 3.[2] Because of these unique attributes and the fear the virus engenders, people with HIV have been subject to social stigma and discrimination.[3]

With no vaccine or cure available or on the horizon, efforts to control the spread of the epidemic have relied upon public education and counselling about the modes of HIV transmission: sexual contact with exchange of

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[1] Defendant's Rule 19 Statement of Undisputed Material Facts at 7, ¶ 24, District Court Docket No. 57; J.A. 171.

[2] *See Update: Trends in AIDS Incidence, Deaths, and Prevalence – United States, 1996*, 46 Morbidity and Mortality Weekly Report No. 8, 165, 171 (1997). Acquired Immune Deficiency Syndrome (AIDS) is the advanced stage of HIV disease and is characterized by a range of "opportunistic infections" and malignancies which would generally not be life-threatening to a person with a normally functioning immune system. J.A. 87, ¶ 3.

[3] *See* Roger Steinbrook, M.D., *Battling HIV on Many Fronts*, 337 New England Journal of Medicine 11, 779-780 (1997) (observing that the "prejudices, fears and legacy of discrimination associated with the [HIV] infection have deep roots in society").

bodily fluids; childbirth or breast feeding; and direct exposure to blood or blood products. J.A. 55-56, ¶ 4.

In contrast to popular perception, however, HIV is difficult to transmit. According to petitioner's own expert, "HIV is a disease of low infectivity." J.A. 171 (p. 64). Although over one billion dental procedures have been performed by over 250,000 dental health care workers in the past fourteen years, and approximately 1,000,000 individuals in the United States are estimated to be infected with HIV, there has never been a documented case of HIV transmission from infected patient to dental health care worker, nor from infected patient to noninfected patient. J.A. 102, 106 (¶ 16).

The American Dental Association, the leading dental association in the United States, has had a policy since 1988 which states:

> Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection for both patients and dental personnel.

Policy Statement on AIDS, HIV Infection and the Practice of Dentistry, American Dental Association (1988:457; 1991:591), J.A. 225.[4] *See also* Brief of the *Amicus Curiae* The American Dental Association, at 1 n.2.

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[4] In 1993, the United States Centers for Disease Control and Prevention (CDC) updated its guidelines on infection control precautions for preventing the transmission of HIV and other bloodborne pathogens in dental offices. First published in 1986, the CDC's guidelines, known as "universal precautions," instruct the practicing dentist how to implement proper procedures to treat all patients *safely*, including those with HIV. J.A. 102, 103-105 (¶¶ 3-6). Ms. Abbott presented testimony from Donald Wayne Marianos, D.D.S., M.P.H., then the CDC's Director of Division of Oral Health, that if dentists "follow universal precautions in their practice, persons with HIV or AIDS . . . can be safely treated in private dental offices." J.A. 105, ¶ 10. Dr. Marianos also testified that no additional infection control procedures are necessary to safely provide routine dental care to patients with HIV. *Id.* at ¶ 7.

On September 16, 1994, Sidney Abbott arrived at petitioner's office in Bangor, Maine for a previously-scheduled appointment. J.A. 145, No. 20. In response to written and verbal inquiries from petitioner about her medical history and HIV status, Ms. Abbott informed the petitioner that she had tested positive for HIV. J.A. 16, 27. Petitioner determined that Ms. Abbott had a cavity which required a filling. J.A. 156, No. 22. Although petitioner routinely fills cavities for his patients in his office, petitioner told Ms. Abbott that he was not willing to fill her cavity in his office because of her HIV status. J.A. 27. It is undisputed that when petitioner refused to fill Ms. Abbott's cavity, he did not consult or seek guidance from anyone, including any public health authority.[5]

Ms. Abbott filed a complaint in the United States District Court for the District of Maine in December, 1994; and the United States and the Maine Human Rights Commission intervened in support of Ms. Abbott's position. After discovery was completed, the District Court granted summary judgment in favor of Ms. Abbott and the two intervenors on all liability issues. *See Abbott v. Bragdon*, 912 F. Supp. 580 (D. Me. 1995) (Appendix to the Petition for Writ of Certiorari, 31a-65a).

The United States Court of Appeals for the First Circuit affirmed the grant of summary judgment in favor

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[5] Although petitioner represented to Ms. Abbott that he would treat her in a hospital setting if she paid the extra hospital charges (J.A. 144, No. 16; 156), he had not even applied for privileges to treat patients at any hospital. J.A. 16, 30-32. After Ms. Abbott filed her complaint against petitioner at the Maine Human Rights Commission on November 1, 1994, he applied for, but never received, privileges at a hospital two hours away from his office. J.A. 231.

of Ms. Abbott, ruling that Ms. Abbott is protected from discrimination under the ADA because HIV is a physical impairment which substantially limits the major life activity of reproduction. *Abbott v. Bragdon*, 107 F.3d 934, 939-942 (1st Cir. 1997) (1a, 7a-15a). The Court of Appeals also added a "final observation" that "Congress deemed HIV-infected individuals to be disabled under the ADA." *Id.* at 942 (15a).[6] In addition, the Court of Appeals determined that Dr. Bragdon did not present any "competent countervailing evidence" to rebut the consensus of public health authorities, including the American Dental Association and the CDC, that "affording routine dental care . . . to HIV-infected patients in an office environment does not pose a direct threat to the dentist's health." 107 F.3d at 945-948 (22a-30a). The Court of Appeals determined that "[e]ach piece of evidence is too speculative or tangential (or in some instances, both) to create a genuine issue of material fact." *Id.* at 947 (29a). The Court of Appeals reviewed the record for cumulative proof and was "satisfied that the evidentiary proffers canvassed above, insufficient in themselves, are likewise insufficient in combination to call into legitimate question the lower court's entry of summary judgment." *Id.* at 948 (29a).

SUMMARY OF ARGUMENT

1. The ADA's definition of disability applies to individuals who have a physical or mental impairment that

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[6] Contrary to petitioner's assertions [Petition at 7 n.6], Ms. Abbott also asserted in both the District Court and the Court of Appeals that she is covered under the "regarded as" prong of the statutory definition of disability. *See* Brief in First Circuit of Sidney Abbott at pp. 31-34, and Argument I.C., *infra*. The United States also made this same "regarded as" argument below. This argument provides independent grounds to affirm the decision of the Court of Appeals.

substantially limits a major life activity as well as individuals who have a "record of," or are "regarded as" having, such an impairment. 42 U.S.C. Section 12102(2). As this Court noted in *School Board of Nassau County v. Arline*, 480 U.S. 273, 280 n.5, 283 (1987), this definition was intended to encompass more than "traditional handicaps" and to protect individuals who were substantially limited due to the negative attitudes of others to their impairment.

2. There is no dispute here that HIV is a physical impairment. The statutory term "physical impairment" refers to a physiological condition which worsens or diminishes one's physiological state. Upon infection, HIV creates abnormalities and deficiencies in the blood and immune systems and renders bodily fluids infectious and diminished in quality.

3. The text and legislative history of the first prong of the ADA's definition of disability show that it was intended to be broad and cover a wide range of serious health conditions which do not comport with the colloquial understanding of the term "disability."

4. Procreation, parenting, and intimate sexual relations are major life activities within the meaning of the ADA. Procreation is "fundamental to the very existence and survival of the race," *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942), and, along with parenting, has long been recognized by this Court as deserving of constitutional protection. Intimate sexual relations is also among the most important of all human activities, fundamental to reproduction, intimacy, and social ordering. The plain language of the ADA, as well as its legislative history, demonstrates that these activities are major life activities.

5. HIV always substantially limits the major life activities of procreation, parenting, and sexual relations. As a fatal, infectious disease, HIV changes substantially the risks and choices associated with reproduction for all who are infected. Everyone who is infected bears the risk of infecting any child he or she may conceive, as well as

his or her sexual partner. In addition, because the disease is fatal, one's ability to raise a child is significantly limited.

6. By setting an unexpected and premature endpoint on life, a fatal disease, such as HIV, limits a wide array of major life activities (including those activities which require thinking about the future) and inevitably changes the experience of life itself. Individuals with HIV are also substantially limited because they require lifelong and complex medical care.

7. Nothing in the text of the ADA requires that every individual make a particularized showing of substantial limitation. To the contrary, many of the provisions of the ADA make little sense unless some impairments are always treated as disabilities. The clear legislative goal of prohibiting discrimination on the basis of HIV status, a goal which the Surgeon General testified was essential to encouraging individuals to be tested, could not be realized if there was uncertainty as to whether every individual with HIV was protected against discrimination.

8. The legislative history of the ADA also shows unequivocally that Congress believed that HIV was universally a disability. This belief is reflected in committee reports as well as in floor statements by both the supporters and opponents of the act. Moreover, pre-ADA case law and administrative interpretations under the Rehabilitation Act establish that there was no doubt when the ADA was enacted that HIV, whether symptomatic or asymptomatic, was a disability. When, as here, Congress re-adopts sections of a prior law, Congress is presumed to have incorporated the prior judicial interpretations of the earlier law. *Lorillard v. Pons*, 434 U.S. 575, 580-581 (1978). That presumption is especially apt here because the ADA specifically states that it shall be interpreted in light of the Rehabilitation Act and its history. 42 U.S.C. Sec. 12201(a).

9. Even if all people with HIV are not disabled under the first prong of the definition of disability, Ms. Abbott made an individualized showing that she is substantially limited in the major life activity of reproduction and is therefore a person with a disability under the ADA.

10. Individuals with HIV infection are also covered under the third prong of the definition of disability. In *Arline*, this Court explained that the third prong applies when an individual is substantially limited due to myths, fears, and stereotypes about an impairment. 480 U.S. at 282-284. HIV, an infectious, fatal disease, is the quintessential stigmatic condition. Individuals with HIV have faced discrimination in all walks of life, but particularly with respect to access to health and dental care. As a result, individuals with HIV, such as Ms. Abbott, have a disability under the third prong.

11. In determining whether the risk of transmission of HIV constitutes a "direct threat to the health or safety of others," courts should apply an objective test and defer to public health authorities, not to the individual views of public accommodations.

ARGUMENT

I. EVERY PERSON INFECTED WITH HIV FALLS WITHIN THE ADA'S DEFINITION OF DISABILITY.

A. INTRODUCTION TO COVERAGE OF HIV UNDER FEDERAL DISABILITY DISCRIMINATION LAW.

The term "disability" in the ADA means, "with respect to an individual":

> (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(B) a record of such impairment;

(C) being regarded as having such an impairment.

42 U.S.C. Section 12102(2).

This definition was not a new creation. It first appeared in the Rehabilitation Act Amendments of 1974, Pub L. No. 93-516, Section 111, 88 Stat. 1617, 1619 (1974), codified at 29 U.S.C. Section 706(8)(B). In those amendments, Congress discarded a narrow, technical definition which focused exclusively on vocational limitations[7] in favor of a three-pronged definition of "handicapped individual." The first prong of the amended definition contained broad language flexible enough to reach a wide range of health problems (i.e., "physical or mental impairment which substantially limits . . . major life activities"). *See* 88 Stat. 1617, 1619 (1974). In addition, because Congress was concerned about discrimination arising from stereotypes and ignorance about physical and mental impairments, Congress added the second and third prongs which include persons with a "record of," or who are "regarded as" having, an impairment. *Id.*; *see also*, S. Rep. No. 1297, 93rd Cong., 1st Sess. 16, 37-38, 50 (1974), *reprinted in* 1974 U.S.C.C.A.N. 6373, 6388-91, 6413-14.

In *Arline*, 480 U.S. at 280 n.5, this Court recognized that the amended definition was "broad" and encompassed more than "traditional handicaps." This Court also explained that Congress intended to prohibit discrimination against persons who may not have any diminished physical capability, but who are substantially

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[7] The Rehabilitation Act of 1973 defined "handicapped individual" to mean: "any individual who (A) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (B) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services." Pub. L. No. 93-112, Section 7(6), 87 Stat. 355, 361 (1973).

limited solely because of the negative attitudes of others towards an impairment. *Id.* at 282-284.

In 1990, Congress enacted the ADA to extend the prohibition against discrimination on the basis of disability to private employers and public accommodations.[8] In so doir.g, Congress re-enacted the Rehabilitation Act's definition of "handicap." A careful and complete reading of the statute and its legislative history demonstrates that under that definition some physical impairments are always disabilities because they have universal consequences. In contrast, other conditions which present a wide spectrum of consequences may constitute a disability for some individuals, but not for others. *See* Argument I.B.2.vi, *infra*.

By the time that Congress enacted the ADA, it understood that HIV – an incurable, fatal and infectious disease – was among those conditions which are universally disabling. When Congress used the identical "non-traditional" definition of "handicap" in the Fair Housing Amendments Act of 1988, Pub. L. No. 100-430, Section 6, 102 Stat. 1619, 1620 (1988), Congress understood that HIV fit squarely within the definition of "handicap." *See* H. Rep. No. 711, 100th Cong., 2d Sess. 18 (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2178-2179. Also in 1988, the Department of Justice construed the Rehabilitation Act to include persons with symptomatic and asymptomatic HIV infection within the protected class.[9] An identical conclusion was reached by every reported federal court

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[8] Pub. L. No. 101-336, 104 Stat. 327 (1990), codified at 42 U.S.C. Section 12101 *et seq.*

[9] *See* Memorandum of Douglas W. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, to Arthur B. Culvahouse, Jr., Counsel to the President (September 27, 1988) ("DOJ Memorandum"), reprinted in *Americans with Disabilities Act of 1989; Hearings Before the Senate Comm. on Labor and Human Resources*, 101st Cong., 1st Sess. 338-368 (1989).

decision under the Rehabilitation Act and the Fair Housing Act prior to the enactment of the ADA in 1990.[10] *See* Argument Section I.B.2.viii, *infra*.

The problem of pervasive discrimination against people with HIV was a keen interest of the ADA's drafters. Congress was concerned not only because discrimination harmed its victims, but also because it undermined the nation's public health efforts to limit the spread of the epidemic.[11] As the President's Commission on the HIV

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[10] In addition, virtually every court since the passage of the ADA has found that HIV is a disability. *See, e.g., Abbott*, 107 F.3d at 939-942 (6a-15a) (1st Cir. 1997); *Gates v. Rowland*, 39 F.3d 1439, 1445 (9th Cir. 1994); *Harris v. Thigpen*, 941 F.2d 1495, 1524 (11th Cir. 1991); *Severino v. North Fort Myers Fire Control District*, 935 F.2d 1179, 1181 (11th Cir. 1991); *Doe v. Garrett*, 903 F.2d 1455, 1458 (11th Cir. 1990); *Hernandez v. Prudential Insurance Company of America*, 977 F. Supp. 1160, 1163-1165 (M.D. Fla. 1997); *Rivera v. Heyman*, 7 A.D. Cases 813, 1997 WL 620837 at *3 (S.D.N.Y. 1997); *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763, 774-777 (E.D. Tex. 1996); *D.B. v. Bloom*, 896 F. Supp. 166, 170 (D.N.J. 1995); *Sharrow v. Bailey*, 910 F. Supp. 187, 191 (M.D. Pa. 1995); *Austin v. Pennsylvania Department of Corrections*, 876 F. Supp. 1437, 1465 (E.D. Pa. 1995); *Howe v. Hull*, 873 F. Supp. 72, 78 (N.D. Ohio 1994); *United States v. Morvant*, 843 F. Supp. 1092, 1093-94 (E.D. La. 1994); *Robinson v. Henry Ford Health Systems*, 892 F. Supp. 176, 179 (E.D. Mich. 1994), *aff'd mem.*, 86 F.3d 1156 (6th Cir. 1996); *Doe v. Kohn, Nast & Graf*, 862 F. Supp. 1310, 1319-1322 (E.D.Pa. 1994); *Support Ministries for Persons With AIDS, Inc. v. Village of Waterford*, 808 F. Supp. 120, 129-132 (N.D.N.Y. 1992); *Stewart B. McKinney Foundation, Inc. v. Town Plan and Zoning Commission of Fairfield*, 790 F. Supp. 1197, 1209 (D. Conn. 1992); *Doe v. District of Columbia*, 796 F. Supp. 559, 567 n.10 (D.D.C. 1992); *Casey v. Lewis*, 773 F. Supp. 1365, 1370 (D. Az. 1991).

[11] *See* S. Rep. No. 116, 101st Cong., 1st Sess. 8, 19 (1989) (referred to hereinafter as "S. Rep."); H. Rep. No. 485, Part 2, 101st Cong., 2d Sess., 31, 48 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303 (referred to hereinafter as "H. Rep. – 2"); H. Rep. No. 485, Part 3, 101st Cong., 2d Sess. 25 n.7 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445 (referred to hereinafter as "H. Rep. – 3").

Epidemic stated in a report whose conclusions were adopted by Congress:

> [A]s long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination . . . will undermine our efforts to contain the HIV epidemic and will leave HIV-infected individuals isolated and alone.

S. Rep. at 8; H. Rep. – 2 at 31.

In order to prevent discrimination from endangering the public health, Congress incorporated into the ADA a pre-existing definition of disability that by its plain language, its previously established legal meaning, and its clear legislative history applies to all persons with HIV (symptomatic or asymptomatic). *See* S. Rep. at 22; H. Rep – 2 at 52; H. Rep. – 3 at 28 n.18.[12]

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[12] Faced with the clear record that everyone in Congress understood that HIV infection is always a disability (*see* Argument, Sec. I.B.2.vii, *infra*), petitioner attempts to trump up an ambiguity in the legislative history where there is none. Petitioner asserts that the implementing regulations for the Fair Housing Act Amendments of 1988 include asymptomatic or symptomatic HIV in the illustrative list of "physical impairments," but do not expressly define HIV as a handicap. Since the Senate Report endorses the analysis of the term "handicap" in the Fair Housing Act regulations, petitioner reasons that the Senate must have believed that HIV infection was an impairment, but not always a disability. Petitioner's Brief at 19-21. Petitioner's claim is misguided. While the regulations under the Fair Housing Act, the Rehabilitation Act and the Americans with Disabilities Act include illustrative examples of physical impairments, *none* identifies any

B. ALL PEOPLE WITH HIV INFECTION HAVE A PHYSICAL IMPAIRMENT WHICH SUBSTANTIALLY LIMITS MAJOR ONE OR MORE LIFE ACTIVITIES.

1. HIV Infection is Always a Physical Impairment.[13]

The ADA does not define the term "physical impairment." However, the natural and ordinary meaning of the word "impair" is "to make worse[;] diminish in quality, value, excellence, or strength[;] do harm to[;] damage, lessen . . . [;] deteriorate." *Webster's Third New International Dictionary of the English Language* (1981). The term "physical impairment" therefore must refer to a physiological condition which worsens or diminishes one's physiological state. This textual understanding is supported by the pre-ADA regulatory analysis of the term "physical impairment" which Congress explicitly adopted.[14]

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disabilities. Therefore, the inference which the petitioner seeks to draw from the regulatory silence does not follow. Moreover, the commentary to the regulations makes clear that HIV was added to the illustrative list of "physical impairments" because "the legislative history of the Act contains numerous statements that HIV infected individuals are covered by the Act." 54 Fed. Reg. 3232, 3245 (Jan. 23, 1989).

[13] Petitioner did not challenge in either the District Court or the Court of Appeals that HIV infection is a physical impairment. This issue therefore is not squarely presented for review in this case. Nevertheless, since a plurality of the Fourth Circuit recently decided that HIV was not a physical impairment, *see Runnebaum v. NationsBank of Maryland, N.A.*, 123 F.3d 156 (4th Cir. 1997) (plurality opinion), we briefly address this issue so that it may be put to rest.

[14] The Department of Health, Education and Welfare regulations defined the term "physical impairment" to mean: "[A]ny physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems . . . [including] the hemic and lymphatic

Based on undisputed medical evidence in the record, HIV fits easily within the plain meaning of "physical impairment." HIV infection is an incurable disease which, even before the onset of outward signs of illness, diminishes bodily functions in two ways. First, HIV creates abnormalities and deficiencies in the blood and immune systems. J.A. 55, ¶ 3. When HIV enters the body, it multiplies and has an immediate and destructive effect on the blood (hemic) and lymphatic systems, which are critical to the body's defense against infection. *Id.* Thus, even before the onset of overt symptoms, HIV infection causes a progressive destruction of the body's blood, lymphatic and immune systems, diminishing the body's capacity to fight infections. *Id.*[15] Second, the bodily fluids of an HIV-positive person, including blood, semen, and breast milk, are infectious. *Id.* at ¶¶ 3-4. In the most basic sense, then, the bodily fluids of a person with HIV are abnormal, damaged, and diminished in quality.[16]

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systems." 45 C.F.R. Section 84.3(j)(2)(i). The ADA expressly adopts the analysis of agency regulations under the Rehabilitation Act. *See* 42 U.S.C. Section 12201(a); *see also* S. Rep. at 50.

[15] Based on this undisputed medical evidence, a person with HIV or AIDS is not merely a "carrier" of a disease. Nor is HIV infection a mere predictor of future illness. HIV is a virus which upon infection begins destroying cells critical to the immune system. Thus, the actual impairment is immediate. Even in individuals who remain without overt symptoms for several years, HIV infection causes an abnormal and weakened immune system. J.A. 55, ¶ 3. *See also* Brief of *Amici Curiae* Infectious Disease Society of America, *et al.*, Section I (hereinafter, the "IDSA Brief").

[16] The ADA regulations and legislative history provide further support that "HIV-positive status simpliciter, whether symptomatic or asymptomatic, comprises a physical impairment." 107 F.3d at 939 (6a). *See* 28 C.F.R. Section 36.104; S. Rep. at 22, H. Rep. – 2 at 51; H. Rep. – 3 at 28 (specifying that "infection with the human immunodeficiency virus" is an impairment).

It is therefore unsurprising that until 1997, no court decision had seriously questioned that HIV infection simpliciter is a physical impairment under federal disability discrimination law.[17] The first case to raise a doubt was *Runnebaum*. The *Runnebaum* plurality is clearly wrong and its reasoning should be clearly rejected by this Court. The statutory language, legislative history, and regulations all dictate that, contrary to the *Runnebaum* plurality's reasoning, the determination of "impairment" is distinct from the inquiry about how the impairment limits life activities. In addition, *Runnebaum* mistakenly equates "impairment" with "visible symptom." Nothing in the text or legislative history supports a requirement that an impairment be visible or outwardly manifest. Many conditions, from epilepsy to lung cancer, may not be visible to others, but indisputably are impairments.

2. HIV Substantially Limits One or More Major Life Activities For All Persons Infected.

i. Congress Deliberately Chose the Broad, Expansive Phrase "Major Life Activity" to Include Health Conditions Which Have the Effect of Making Life More Difficult.

The first prong of the ADA's definition of "disability" includes impairments which "substantially limit one or more major life activities." 42 U.S.C. Section 12102(2)(a). In

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[17] Prior to 1997, every federal case easily concluded that HIV is a physical impairment. *See, e.g., Gates v. Rowland*, 39 F.3d at 1445; *Leckelt v. Board of Commissioners of Hospital District No. 1*, 909 F.2d 820, 825 (5th Cir. 1990); *Austin v. Pennsylvania Department of Corrections*, 876 F. Supp. at 1465; *Doe v. Kohn, Nast & Graf*, 862 F. Supp. at 1319-1320; *Doe v. District of Columbia*, 796 F. Supp. at 566; *Cain v. Hyatt*, 734 F. Supp. 671, 677-678 (E.D. Pa. 1990); *Baxter v. City of Belleville*, 720 F. Supp. 720, 725 (S.D. Ill. 1989).

construing this definition, this Court looks first to the statute's language and context. *See Reves v. Ernst & Young*, 507 U.S. 170, 177 (1993).

The plain language of the first prong reflects Congress' rejection of a narrow, technical definition in favor of a broad, flexible concept designed to facilitate the statutory goal of enabling "forty-three million Americans" to live full, independent and economically self-sufficient lives. *See* 42 U.S.C. Section 12101(a)(1) and (8). The language is broad and inclusive because Congress wanted all people with serious health conditions to have the opportunity to work, be self-reliant and have access to public places and services. *See* 42 U.S.C. Section 12101(a)(9) ("discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and . . . costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity").

To achieve these goals, the ADA includes more than conditions which are so debilitating as to be incompatible with work and the enjoyment of public accommodations.[18] Indeed, it was the precise goal of the ADA to ensure that individuals who experience some health-based limitations, but can work and be self-supporting, be protected from discrimination so that they can work and be self-sufficient. If the ADA did not cover such people, those who could work might be unable to do so

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[18] In contrast, Congress defined the term "disability" in the Social Security Act as: "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. Section 1382c(a)(3)(A).

solely due to discrimination.[19] Thus to promote independence, the statutory text covers a wide range of serious health conditions which do not necessarily comport with the colloquial understanding of the term disability. At the same time, the definition of disability would exclude trivial or short-lived conditions such as influenza or a broken ankle. *See* H. Rep. – 2 at 52; S. Rep. at 23.

The phrase "major life activities" facilitates these statutory goals because, as the Court of Appeals correctly noted, the "plain meaning of the word 'major' denotes comparative importance" or "significance" and the term "life" is "notable for its breadth." 107 F.3d at 939-940 (8a-9a). *See also Doe v. Kohn, Nast & Graf, P.C.*, 862 F. Supp. at 1320 (finding that HIV is a disability, and noting that the "term 'major life activities' . . . encompasses a lot [and includes] the various major activities embraced within the full scope of one's life"). The phrase "life activities" encompasses a wide, expansive range and array of tasks, functions and pursuits which most people would engage in. *See* S. Rep. at 23; H. Rep. – 2 at 52 (describing major life activities as "important life activities"). Congress easily could have chosen to use (but did not) a narrower,

[19] Importantly, falling within the statutory class is of no relevance unless there is discrimination due to the health condition at issue. Moreover, the breadth of the definition is balanced by the limiting or restricting principles in the substantive discrimination provisions. For example, under Title I, an individual with a disability cannot prevail on an ADA claim unless he or she is a "qualified individual with a disability." 42 U.S.C. Sections 12111(8) and 12112(a). Similarly, individuals with a disability are entitled to a "reasonable accommodation" only when it does not impose an undue hardship, 42 U.S.C. Section 12112(b)(5)(A), or fundamental alteration of services. 42 U.S.C. Section 12182(b)(2)(A)(ii). Even blatant, invidious discrimination is permitted if the disability creates a "direct threat to the health or safety of others." 42 U.S.C. Sections 12113(b) and 12182(b)(3).

more restrictive phrase such as "essential life activities" or "daily life activities." The phrase "life activities" is thus broad enough to cover both the activities listed in the regulations[20] as well as some other important and basic life activities including procreation, parenting, intimate sexual relations, decision making about such matters, as well as maintaining health and living itself.

ii. Procreation, Parenting, and Intimate Sexual Relations are Major Life Activities.

Procreation, the life activity which creates *life* itself, is plainly a "major life activity." *See* 107 F.3d at 939 (8a) ("reproduction, which is both the source of all life and one of life's most important activities, easily qualifies [as a major life activity]"); *Pacourek v. Inland Steel Co., Inc.*, 916 F. Supp. 797, 804 (N.D.Ill. 1996). This Court has long recognized the importance of procreation, noting that it is "fundamental to the very existence and survival of the race." *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Accordingly, an individual's interest in deciding whether or not to conceive and raise children and in actually doing so is a fundamental liberty interest, deserving of

[20] On its face, the Title III regulation defining "major life activities" is illustrative and open-ended. *See* 28 C.F.R. Section 36.104 ("major life activities means functions *such as* caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working") (emphasis supplied); *see also*, 107 F.3d at 940 (8a) (noting that the regulation "clearly . . . indicates [that the] enumeration is not meant to be exclusive . . . "). The import of this non-exhaustive list is that the statutory phrase is too broad and flexible to make a complete enumeration possible.

constitutional protection.[21] *See, e.g., Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 849 (1992) (fundamental liberty to make decisions about family and parenthood); *Carey v. Population Services International*, 431 U.S. 678, 684 (1977) ("The decision whether or not to beget or bear a child is at the very heart of this cluster of constitutionally protected choices."); *Stanley v. Illinois*, 405 U.S. 645, 650 (1972) (unwed father's due process right to companionship, care and custody of his children). Perforce this interest falls within the broader category of a "major life activity."[22]

In addition, it defies common sense to argue that intimate sexual relations is not an activity of the utmost importance. Sexual relations is one of the most basic activities which humans engage in and, for the most part, is the *sine qua non* for reproduction. Decisions about sexual relations have always been fundamental to social ordering and lie at the heart of human relationships,

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[21] Numerous other courts have correctly ruled that reproduction is a major life activity. *See Bielicki v. City of Chicago*, 1997 U.S. Dist. LEXIS 6880 (N.D. Ill. 1997) at *8; *Hernandez v. Prudential Life Insurance Company of America*, 977 F. Supp. at 1163; *Rivera v. Heyman*, 7 A.D. Cases 813, 1997 WL 620837 at *3; *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. at 777 n.37; *Pacourek v. Inland Steel Co., Inc.*, 916 F. Supp. at 804; *Austin v. Pennsylvania Department of Corrections*, 876 F. Supp. at 1465; *Erickson v. Bd. of Governors of State Colleges*, 911 F. Supp. 316 (N.D. Ill. 1995); *Doe v. Kohn, Nast & Graf*, 862 F. Supp. at 1320-21; *Cain v. Hyatt*, 734 F. Supp. 671, 678 (E.D. Pa. 1990); *Thomas v. Atascadero Unified School District*, 662 F. Supp. 376, 379 (C.D. Cal. 1986).

[22] Clearly many of the major life activities recognized by the statutory term are not entitled to any heightened protection under the Due Process Clause. The point, however, is that if an activity is constitutionally protected, it stands to follow that it falls within the broader and less rigorous category of "major life activities."

intimacy, and socialization. Moreover, the inclusion of intimate sexual relations within the category of "major life activity" is consistent with the legislative history in which Congress specified that the term "major life activities" includes procreation and intimate sexual relations. H. Rep. – 2 at 52.

Petitioner never addresses the statutory language, which this Court has observed is not limited to "traditional handicaps." *Arline*, 480 U.S. at 280 n.5. Instead, he claims that neither procreation nor sexual relations are major life activities because the ADA regulates public life, not private matters.[23] Petitioner's Brief at 27-31. This position is without merit for two reasons. First, the text of the ADA makes clear that the question of who has a disability, and is therefore simply within the protected class, is distinct from the issue of where discrimination is prohibited. Second, petitioner's argument is predicated on the assumption that a covered entity must be able to see an individual's substantial limitation in order for that individual to have a disability. This is plainly false. Many conditions which will often be substantially limiting are invisible. For example, epilepsy, pancreatic cancer or bipolar disorder may not be visible to others yet under the statute, an employer is restricted in its ability to inquire

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[23] Petitioner attempts to frighten this Court with the specter of millions of individuals with infertility seeking protection under the act if reproduction is a "major life activity." *See* Petition at 9. But, in fact, even if some forms of infertility constitute disabilities, individuals with that condition would not have unlimited rights. It is worth repeating that the act contains numerous substantive limitations, *see* n.19, *supra*, such as the requirement that accommodations be reasonable and not cause an undue burden. Moreover, the provision of insurance benefits, especially relevant to infertility, is separately treated by the ADA's safeharbor provision. 42 U.S.C. Section 12202(c).

about the existence of these conditions. *See* 42 U.S.C. Section 12112(d)(4)(A) (prohibiting certain examinations and inquiries as to whether an individual has a disability "or as to the nature or severity of the disability").

Petitioner also contends that reproduction cannot be a major life activity either because it is a lifestyle choice or because it is not necessarily engaged in with frequency, citing *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 677 (9th Cir. 1996) and *Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd mem.*, 79 F.3d 1143 (5th Cir. 1996).

These arguments are flawed and should be rejected. First, the starting place for statutory interpretation is the language of the statute followed by its legislative history. *See, e.g., Blum v. Stenson*, 465 U.S. 886, 896 (1984). The two cases relied upon by petitioner completely disregard both. Instead, they focus on a narrow reading of one section of the regulations. As the Court of Appeals held in this case, *Krauel* treated the list of activities in the regulation as exclusive, not illustrative, contrary to the regulation's plain language. 107 F.3d at 940 (8a).[24] In addition, there is no evidence in the statute's text or the regulations that "Congress intended either frequency or universality to operate as a restriction on the definition of 'major life activities.' " 107 F.3d at 940 (10a).[25] To confine

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[24] Indeed, the ADA Title III regulation supports the conclusion that reproduction is a major life activity. The regulations define the term "physical impairment" to include physiological disorders affecting the reproductive system. *See* 28 C.F.R. Section 36.104. This indicates that "[the ADA's] drafters considered reproduction to be a major life activity – otherwise, including reproductive disorders among the regulation's roster of physical impairments would not have made much sense." 107 F.3d at 940 (9a), citing *Pacourek*, 916 F. Supp. at 801-802.

[25] The Court of Appeals observed that the activities "explicitly enumerated in the regulation are not wholly

a major life activity only to those activities which occur every day or are necessary to exist ignores the statutory language and history as well as the significance of procreation and intimate sexual relations to life.

iii. In Order to Limit Substantially a Major Life Activity, a Physical Impairment Must Restrict, Confine, or Set a Boundary On, But Need Not Preclude, the Activity.

Under the first prong of the definition of disability, a physical impairment constitutes a disability if it substantially limits a major life activity. The plain meaning of "limits" is to "restrict," "confine within limits, to set bounds to." VIII *Oxford English Dictionary* 965 (1989). *See also, American Heritage Dictionary* 1044 (1992) ("to confine or restrict within a boundary or bounds"). Congress' choice of the words "substantially limits" rejects any requirement that an individual absolutely cannot or chooses not to engage in a particular life activity. *See also*, 28 C.F.R. Part 36, App. B Section 36.104 (a person is substantially limit[ed] in any activity if, "in comparison to most people," he or she is "restricted as to the conditions, manner or duration under which it can be performed"); S. Rep. at 23; H. Rep. – 2 at 52 ("A person is considered an individual with a disability for purposes of the first prong of the definition when an individual's important life activities are restricted as to the conditions, manner or duration under which they can be performed in comparison to most people.").

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characterized by frequency or universality." 107 F.3d at 940 (11a) (noting that work, for example, is not universal as "the lives of some of the very rich and some of the very poor demonstrate.").

This Court in *Arline* recognized that the "substantial limitation" requirement was not rigorous. The *Arline* Court quickly and easily determined that the plaintiff was substantially limited in a major life activity simply because she had been hospitalized on one occasion, without need for any further inquiry. *See* 480 U.S. at 281.[26]

iv. HIV Substantially Limits the Major Life Activities of Procreation, Parenting, and Intimate Sexual Relations.

Because of HIV's infectiousness, procreation, parenting, and intimate sexual relations are the most obvious, but certainly not the only, life activities which are substantially limited by HIV infection. Procreation is substantially limited because an HIV-positive man and an HIV-positive woman risk infecting both their sexual partners as well as any children they conceive. An HIV-positive mother can transmit HIV to a child during breast feeding. Even if a child is born uninfected, the fatal nature of HIV infection means that a parent is unlikely to live long enough to raise and nurture the child to adulthood. Obviously, this impacts on an individual's decision as to whether or not to have a child and, if so, how to raise the child. As the Court of Appeals noted, and no party seriously disputed, "HIV-positive status has a profound impact upon [the] ability to engage in intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations." 107 F.3d at 939 (7a).

In addition, all people with HIV infection, even if they practice "safer sex," can infect others with a life-threatening disease if there is an exchange of bodily

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[26] Indeed, if an activity had to be absolutely precluded in order to be substantially limited, no one could ever be found to have a substantial limitation of the major life activity of breathing.

fluids during sexual activity. Certainly the risk that a deadly disease will result from an activity inherently limits, restricts, and sets boundaries on the activity. The fear and concern of others about the infectiousness of HIV, and the fatal nature of the disease, also make intimate sexual relations and procreation more difficult for people who are HIV-infected.

HIV's limitation on procreation and intimate sexual relations is universal and does not depend on the particular intentions which any individual may hold at a particular point in time. People commonly change their plans and intentions about procreation and intimate sexual relations throughout the course of their lives. Therefore, even if an HIV-infected individual believes today that he or she would refrain from these activities, even in the absence of HIV infection, he or she is still substantially limited because future options are restricted. Such an individual never has the opportunity to change his or her intentions and engage in procreation and intimate sexual relations without the dangers of infectiousness and fatality. As such, HIV permanently forecloses options to engage in some of the most fundamental and important life activities in the same way that uninfected persons can. Likewise, even if an individual chooses, despite the infection, to engage in those activities, he or she is still substantially limited because he or she is facing risks and limitations not experienced by those who are uninfected.

The petitioner asserts that people with HIV cannot be limited in procreation or sexual relations because HIV does not make those activities physically impossible. Petitioner's Brief at 39-40. The ADA's text, however, requires only a physical or mental impairment "that substantially limits one or more . . . major life activities." Neither the text, the legislative history nor the regulations require that the impairment preclude the activity. They only require that *but for* the impairment, the individual would

not be substantially limited.[27] In the case of HIV, *all* individuals are so limited with respect to the major life activities of procreation, parenting and intimate sexual relations.

v. A Fatal Disease Such as HIV Necessarily Limits a Wide Array of Major Life Activities, Including Caring For One's Self.

As long as HIV is an infectious, incurable, universally fatal disease, it inevitably limits substantially an array of major life activities. By setting an unexpected and premature endpoint on one's life, a fatal illness necessarily limits that life, and any life activities which require thinking about the future. Decisions about such matters as family, working, learning or education, even whether to buy a home, are restricted by the shortened nature of life itself. Thus, even in the implausible event that an individual with a fatal illness experienced neither any physical or psychological effect from the illness, simply by shortening life, the physical impairment would substantially limit many major life activities.

But in reality, a fatal illness does more than merely set an endpoint on an individual's life. A fatal illness inevitably changes the experience of life itself. *See* Brief of

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[27] The ADA covers persons whose lives are substantially limited by physical or mental impairments, not by economic or environmental factors. Petitioner divorces the "substantial limitation" of an activity from the link to the "physical impairment" by claiming that poor women whose babies may live "short and miserable lives" could be covered by the ADA. Petitioner's Brief at 41. This is patently absurd. Similarly, post-menopausal women or individuals who choose to limit their fertility through family planning are not limited by a physical impairment any more than a person with an inheritance who chooses not to work is covered by the ADA because of a "substantial limitation" to working.

Amicus Curiae American Medical Association, Med. Background, Section B.II. Although "[d]eath will be different for each of us," *Washington v. Glucksburg*, ___ U.S. ___, 117 S. Ct. 2302, 2303 (1997) (O'Connor, J., concurring), the experience of facing death is never trivial. Individuals with a fatal illness commonly experience a wide range of psychological reactions, that may include denial, isolation, anger and depression. Elisabeth Kubler-Ross, *On Death and Dying* (1969), *passim*.[28] While the particular reactions may vary among individuals, it defies credulity to deny that the shadow of premature mortality significantly changes life, thereby necessarily limiting life activities.[29] To rule that people with universally fatal diseases are not protected from discrimination until they are significantly debilitated would undermine the statutory goal of ensuring that people with serious health conditions have equal opportunity.

The Title III regulations also recognize that "caring for one's self" is a major life activity. 28 C.F.R. 36.104. "Caring for one's self" necessarily includes the ability to care for one's health and, in some circumstances, to obtain the health care necessary to do so. *See Hernandez*, 977 F. Supp. at 1165 ("caring for one's self" includes need for continued medical care). In *Arline*, this Court found that the plaintiff faced a substantial limitation of a major

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[28] *See also*, Andrew E. Slaby, M.D., Ph.D., M.P.H., Arvin S. Glicksman, M.D., *Adapting to Life-Threatening Illness*, Praeger Special Studies, 1985 at 8 ("The awful awareness of the fragility of the fabric of life creates, in all but the most insensitive, a crisis – a turning point. The abstract assumption that we will not live forever becomes a personal reality for those with life-threatening illnesses and for those around them.").

[29] The fact that HIV progresses slowly in a very small number of cases does not alter the impact of the anticipated fatality of HIV since no person can possibly know whether he or she will be among those rare cases.

life activity simply because she had required hospitalization. 480 U.S. at 281. Since no other major life activity was cited, the clear implication is that by virtue of the fact that Arline required extensive medical care to become healthy, she was limited in the major life activities of caring for herself and maintaining health.

HIV infection, like tuberculosis, necessarily requires ongoing medical monitoring and complex, burdensome medical treatment, except that HIV, unlike tuberculosis, requires life-long treatment. The standard treatment for HIV disease involves multiple combinations of toxic antiviral drugs and entails intensive, difficult treatment regimens. *See* IDSA Brief, Section II.A. As an editorial about HIV treatment in the prestigious medical journal The Lancet recently noted:

> It is difficult to adhere to anti-retroviral treatment regimens. Many pills have to be taken at awkward times that interfere with normal eating patterns. So many patients find it impossible to comply with such a regimen for the rest of their lives and as a result multiple drug resistance develops.

See Paul A. Volberding, *Protease Inhibitors Vindicated*, The Lancet, vol. 350 (suppl. III): 10 (1997).[30]

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[30] Unfortunately, recent advances in HIV treatment have significant limitations. Many patients do not respond or cannot tolerate the medications and in any event it is not clear how long the drugs will work for anyone. The transformation of HIV to a chronic manageable disease is not on the horizon. *See* Steven G. Deeks, M.D., et al., *HIV-1 Protease Inhibitors: A Review for Clinicians*, 277 Journal of the American Medical Association No.2: 145 (1997) (noting that the new treatments have "significant adverse effects," that long-term efficacy has not been determined, in part due to the possibility that resistance will impede drug activity, and that the drugs are not effective in all patients).

In addition, regular, preventative health care, including dental care, is critical to maintaining health for people with HIV. J.A. 87, ¶ 4. Access to such care is made more difficult by well-documented discrimination against people with HIV.[31] This discrimination not only deters people with HIV from seeking care, but also deters patients from disclosing HIV status to providers of routine health care, such as dentists. Petitioner cannot argue that people with HIV, such as Ms. Abbott, should be denied routine health care (or be forced to travel four hours and pay an extra fee simply to have a cavity filled), but yet claim that they are not limited in any major life activity.[32] *See, e.g., Austin v. Pennsylvania Department of Corrections*, 876 F. Supp. at 1465 (HIV "by its biologic effects and the fear it inspires in others, clearly limits those infected in major life activities").

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[31] The President's Commission on the HIV Epidemic noted in its 1990 report to the President and Congress that "the number [of dentists willing to treat people with HIV] remains grossly inadequate and unacceptable. The difficulty, and in many cases inability, of obtaining dental services is . . . an all too common problem for people living with HIV infection and AIDS." *See* President's Commission on the HIV Epidemic, Annual Report to the President and Congress 163 (August 1990). *See also*, M. Elizabeth Bennett, Ph.D., et al., *A National Survey: Dentists' Attitudes Toward The Treatment of HIV-Positive Patients*, 126 Journal of the American Dental Association 509 (April, 1995); C. Lewis, M.D. & M.D. Montgomery, M.D., *Primary Care Physicians' Refusal to Care for Patients Infected with Human Immunodeficiency Virus*, 156 Western Journal of Medicine 36 (1992).

[32] While the limitation in this sense is not solely due to the physical effects of HIV, it remains true that the biology of the physical impairment creates the infectiousness of HIV and the increased need for medical care.

vi. The Text and Purpose of the ADA Demonstrate That Certain Impairments, Including HIV, are Always Disabilities.

While the ADA creates causes of action for individuals with disabilities, a careful examination of the "statute's full text, language, structure and subject matter,"[33] demonstrates that some impairments – such as quadriplegia, blindness, and HIV infection – have predictable consequences which are universally limiting.[34] When an impairment always limits substantially major life activities, nothing in the text requires the individual to provide particularized proof of the nature and extent to which the impairment substantially limits his or her major life activities. In such cases, the plaintiff should be found to have a disability upon establishing that he or she has an impairment that is universally limiting (e.g., permanent contagiousness, incurability, and fatality).

Indeed, the ADA's text frequently refers to a "class of individuals with disabilities," suggesting that there are

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[33] *See United States National Bank of Oregon v. Independent Insurance Agents of America, Inc.*, 508 U.S. 439, 454 (1993).

[34] Other impairments may not have universal consequences for each person with the impairment. In other words, some impairments have a wide range of possible consequences from *de minimis* to life-threatening. For example, allergies and arthritis are not substantially limiting for every person with either impairment. The breadth and flexibility of the definition of "disability" permits persons with those impairments to make an individualized showing of substantial limitation. This type of individualized approach is a way to broaden the statute, not narrow it. Petitioner's claim that this Court in *Arline* made an individualized determination of whether the plaintiff's tuberculosis was substantially limiting does not refute the principle that there are impairments which are always limiting. Tuberculosis, unlike HIV, is not terminal and is not permanently contagious.

some impairments which are always disabilities, and therefore can be identified and treated as a class. *See, e.g.*, 42 U.S.C. Section 12182(b)(2)(A)(a)(i); 42 U.S.C. Section 12112(b)(6).[35] Moreover, an insistence on particularized proof after the event of discrimination would lead to serious public health consequences and absurd results. The undisputed purpose of the ADA is to "provide a clear and comprehensive national mandate for the elimination of discrimination against people with disabilities." 42 U.S.C. Section 12101(b)(1); S. Rep. at 2. If a particularized assessment was always required, no one could ever know until after the fact whether an individual had a disability. A "clear and comprehensive mandate" would hardly exist.

Critically, Congress determined that coverage of all people with HIV under the ADA was critical to public health efforts to combat the spread of the epidemic. The House Report noted that:

> As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling and care. This fear of potential discrimination . . . will undermine our efforts to contain

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[35] In the legislative history, Congress was explicit about the provisions of the ADA which required an individualized, case-by-case assessment. For example, Congress was explicit that the determination of reasonable accommodation is a "fact-specific case-by-case approach" and must be determined on "particular facts." *See* S. Rep. at 31. Similarly, Congress was explicit that the determination of "direct threat" "must be made on a case-by-case basis . . . [and] requires a fact-specific individualized inquiry . . . " S. Rep. at 27. Although each of the committee reports discusses the definition of "individual with a disability" in depth, none discuss the need for a particularized assessment of whether an individual has a "disability."

> the HIV epidemic and will leave HEV-infected (*sic*) individuals isolated and alone.

H Rep. – 2 at 31, *quoting* Report of the President's Commission on the Human Immunodeficiency Virus.[36] As then-Surgeon General C. Everett Koop testified to Congress, "[i]f counseling [about HIV prevention] and testing are to work most effectively, individuals must have confidence that they will be protected fully from HIV-related discrimination." *See Americans with Disabilities Act of 1989: Hearings Before the Senate Comm. on Labor and Human Resources*, 101st Cong. 367 (1989).[37] If the legality of discrimination depends upon an uncertain particularized inquiry, that confidence cannot exist.

Moreover, requiring a particularized assessment will often lead to absurd results.[38] For example, a dentist

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[36] *See also*, Statement of Senator Moynihan, 135 Cong. Rec. S10794 (Sept. 7, 1989) (citing the importance of ending discrimination, including for public health reasons, and noting that ADA covers "people with a diagnosis of HIV infection").

[37] These critical public health goals are as true today as at the time the ADA was enacted in 1990. *See* Steinbrook, M.D., n.3, *supra* (declaring that current public health strategies are "most likely to succeed as part of an overall strategy that incorporates protection against discrimination . . . [and noting that the] prejudices, fears and legacy of discrimination associated with the infection have deep roots in society"). Indeed, today with the danger that the virus will become drug resistant if patients do not follow strict regimens, it is particularly important that individuals not fear discrimination. *See* Brief of *Amicus Curiae* Elizabeth Glaser Pediatric AIDS Foundation, Section I.A. (discussing case of school child who avoided taking medications in class).

[38] *Amicus Curiae* American Dental Association points to cases requiring an individualized determination of disability. *See* Brief at 10-12. Because many impairments have a wide range of physiological effects, an individualized assessment is at times appropriate. *See, e.g., Homeyer v. Stanley Tulchin Associates, Inc.*,

would be able to discriminate against some people with HIV, but not others, even though there is no distinction between the infectiousness of the two groups. Indeed, who gets care and who is denied care could depend upon limitations to major life activities which might not even be known to a dentist and which would be irrelevant to the question whether dental care should be provided. If an individual could not be assured that discrimination would be prohibited, he or she might well be tempted to either forego care or hide the condition.[39]

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91 F.3d 959, 962 (7th Cir. 1996) (individualized inquiry necessary to determine whether allergy to smoke constitutes a disability); *Katz v. City Metal Co.*, 87 F.3d 26, 32 (1st Cir. 1996) (individualized inquiry necessary to determine whether cardiac condition is a disability). For the most part, courts have insisted upon an individualized inquiry in cases in which the plaintiff has cited the inability to perform a single job as the major life activity. *See, e.g., Forrisi v. Bowen*, 794 F.2d 931 (4th Cir. 1986); 29 C.F.R. Section 1630.2(j)(3)(i). However, to the extent that some lower courts have gone beyond the particular facts and conditions before them to suggest that a highly particularized showing of substantial limitation is required in every single case, they have added a requirement not present in the clear text of the statute, and contradicted by the structure and legislative history of the ADA, as well as the common practice under the Rehabilitation Act. *See, e.g., United States v. University Hospital*, 729 F.2d 144, 155 (2d Cir. 1984) (finding that infant has a handicap under the Rehabilitation Act because she will be mentally retarded, without requiring further analysis as to how that retardation will substantially limit her major life activities).

[39] Petitioner himself points to the absurdity of an individualized approach by arguing that he could not know the nature of Ms. Abbott's limitations. Petitioner's Brief at pp. 41-42. The petitioner does not, however, contend that people with HIV never have a disability. With a particularized

An individualized approach would make it particularly hard for children to establish disability under the first prong. Clearly, Congress could not have intended that the statute be interpreted in such a way that an HIV-positive school child could be barred from school merely because the child could not make an individualized showing as to how his or her own HIV substantially limited major life activities.[40] In short, demanding a particularized assessment would undermine the statute's anti-discrimination provisions, while creating uncertainty about legal obligations for both covered entities and employees or customers alike.

vii. The Legislative History and Agency Regulations Also Compel the Conclusion That All Persons with HIV are Covered Under the ADA.

The ADA's legislative history reinforces the clear intent of the statutory language that some impairments, such as HIV infection, are always disabilities. *See United States v. Clark*, 454 U.S. 555, 561 (1982) ("Although the language of the statute is clear, any lingering doubt as to its proper construction may be resolved by examining the legislative history . . . "). Congress repeatedly expressed a

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approach, he would always be in the same quandary. Indeed, petitioner could claim the right to refuse to treat a person with lung cancer because the patient had not proven that he or she was limited in major life activities.

[40] Indeed, the problem of HIV-positive children being barred from schools was common in the 1980s and formed the basis for many of the early cases holding that HIV was a disability. *See, e.g., Thomas v. Atascadero Unified School District*, 662 F. Supp. 376 (C.D. Cal. 1986); *Ray v. School District of DeSoto County*, 666 F. Supp. 1524 (M.D. Fla. 1987). Under petitioner's approach, many, if not most, of those cases would have been wrongly decided.

unanimous and unequivocal understanding in the legislative history that all individuals with HIV are covered under the ADA's definition of "disability." That conclusion is not based on a few stray floor statements, but is clearly repeated in many committee reports, innumerable floor statements and was even clearly understood by those who challenged the wisdom of the legislation.

The official House Report to the ADA in a section titled "Explanation of the Legislation – Definition of the Term Disability" states:

> [A] person who is a paraplegic will have a substantial difficulty in the major life activity of walking; a deaf person will have a substantial difficulty in hearing aural communications; and a person with lung disease will have a substantial limitation in the major life activity of breathing. As noted by the U.S. Department of Justice . . . a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term "disability" because of a substantial limitation to procreation and intimate sexual relationships.[41]

In addition, committee reports specifically refer to persons with HIV infection in describing the discrimination prohibited by both Titles I and III of the ADA. *See* S. Rep. at 34 ("[I]t would be unlawful [under Title I] to transfer unilaterally a person with *HIV infection* from a job as a

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[41] *See* H. Rep – 2 at 52. *See also*, S. Rep. at 22; H. Rep. – 3 at 28 n.18 (reaching the identical conclusion). The House Report expressly adopted a 1988 official legal memorandum of the Department of Justice which concluded that asymptomatic HIV was a disability under the Rehabilitation Act. The Department of Justice based this conclusion in part on the substantial limitation to the major life activities of procreation and intimate sexual relations. *See* DOJ Memorandum, n.9, *supra*, attached as Exhibit E to the United States' Motion For Summary Judgment, Docket No. 52, September 19, 1995.

teacher to a job where such person has no contact with people.") (emphasis added); S. Rep. at 63 (stating that drug rehabilitation clinic could "not refuse to treat a person who was a drug addict simply because the patient tests positive for HIV"). *See also,* H. Rep. – 2 at 65, 106 (same).[42]

There is no ambiguity or disagreement in the legislative history about whether the ADA covers all people with HIV infection. Even legislators who opposed some aspects of the ADA understood and *assumed* that the act would apply to all persons with HIV.[43]

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[42] *See also,* Statement of Representative McDermott, 136 Cong. Rec. H2626 (May 22, 1990) (HIV-positive individuals are "covered under the first prong of the definition of disability in the ADA . . . As a physician, I know that although the major life activity that is affected at any point along the spectrum by the HIV infection may be different, an effect on some major life activity exists from the time of HIV infection").

[43] *See, e.g.,* H. Rep. – 3 at 92-93, Dissenting Views of Honorable Chuck Douglas ("as presently drafted, a food service operator could not even *transfer* an employee with AIDS, or one who has tested positive for the AIDS virus out of a food-handling position . . . The reasons the employer could not are . . . [that] the person *does not* pose a direct threat to the health and safety of other workers and patrons") (emphasis in original).

In addition, there was an extended debate about an amendment to exempt food-handling employees who were diagnosed with an infectious or contagious disease such as HIV. The amendment was defeated, but the debate makes clear that the legislators unanimously understood that the definition of disability covered all persons with HIV, not just those with symptoms. *See* 136 Cong. Rec. 2478, 2483 (May 17, 1990); (Statements of Representatives Chapman, Engel and Pelosi); *id.* at S7436 (June 6, 1990) (Sen. Helms); *id.* at S7438 (Sen. Harkin); *id.* at S7443-46 (Sens. Kennedy, Cranston & Durenberger); *id.* at H4612 (July 12, 1990) (Rep. Dannemeyer); *id.* at H4628 (Rep.

In addition, Congress expressly authorized the Attorney General to issue regulations implementing Title III. *See* 42 U.S.C. Section 12186(b). The Preamble to these regulations cites and adopts the 1988 DOJ Memorandum which concludes that people with asymptomatic HIV are covered under the Rehabilitation Act, because HIV substantially limits the major life activities of procreation and intimate sexual relations. *See* 28 C.F.R. Part 36, App. B Section 36.104. The Equal Employment Opportunity Commission has taken the same position under Title I of the ADA. *See* EEOC, *Technical Assistance Manual on the Employment Provisions (Title I) of the Americans with Disabilities Act*, at T-II (January 1992) ("Some impairments, such as blindness, deafness, HIV infection or AIDS, are by their nature substantially limiting").

viii. The Legal History of Federal Disability Discrimination Laws Demonstrates That HIV Infection is Always a "Disability" Under the ADA.

The conclusion that HIV is always a disability is further supported by the fact that prior to 1990 the term "individual with a handicap" had been clearly established under federal disability discrimination laws to include all people with HIV. Prior to the passage of the ADA, every reported decision under the Rehabilitation Act and the Fair Housing Act had determined that asymptomatic HIV constituted a disability. *See Doe v. Garrett*, 903 F.2d at 1459 ("[W]e note that it is well established that infection with AIDS constitutes a handicap for purposes of the [Rehabilitation Act]"); *Cain v. Hyatt*, 734

Hoyer quoting Pres. Bush). *See also,* dialogue between Senators Harkin and Helms (135 Cong. Rec. S10765-10768) in which Senator Helms expressed his clear understanding that the ADA covered all HIV-positive persons.

F. Supp. at 679 (even when asymptomatic, "HIV infection constitutes a substantial physical limitation upon major life activities"); *Baxter v. City of Belleville*, 720 F. Supp. at 725-728 (finding that HIV-positive persons are covered under the Fair Housing Act because they are infectious from first day of contracting disease and immunological deterioration begins on first day of becoming infected; and finding that the inability to reside in group residence due to public misapprehension about HIV adversely affects major life activities); *Thomas v. Atascadero Unified School District*, 662 F. Supp. at 379 ("People infected with the AIDS virus suffer significant impairments of their major life activities . . . Even those who are asymptomatic have abnormalities in their hemic and reproductive systems making procreation and childbirth dangerous to themselves and others").

When Congress adopts a new law incorporating sections of prior law, Congress is presumed to be aware of prior judicial interpretations and adopt them in the new statute. *Lorillard v. Pons*, 434 U.S. at 580-581. *See also, Keene Corp. v. United States*, 508 U.S. 200, 212-213 (1993) (presumption that Congress is aware of and adopts earlier judicial interpretations); *Pierce v. Underwood*, 487 U.S. 552 (1988) (Where Congress re-enacts a statute that had in fact been given a consistent judicial interpretation, along the lines the committee reports suggest, such re-enactment generally includes the settled judicial interpretation). Such a presumption is especially warranted here because Congress expressly directed that the ADA shall be interpreted consistently with such prior legal history. *See* 42 U.S.C. Section 12201(a).[44]

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[44] The prior legal history also includes Congress' understanding of the Fair Housing Amendments Act of 1988. *See, supra,* at Argument Section I.A., p. 9. In addition, Congress amended the Rehabilitation Act in the Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (1988), codified at 29 U.S.C. Section 706(8)(D), to codify the "direct threat" standard in *Arline*. *See* 134 Cong. Rec. 2924 (March 2, 1988), Statement of Representative Coehlo: "People with contagious diseases and infections such as people with AIDS or people infected with the AIDS virus can be subject to intense and irrational discrimination. I am pleased that this amendment makes clear that such individuals are covered under the protections of the Rehabilitation Act." *Id.* at 2937, Statement of Representative Weiss: "[I]ndividuals who are suffering from a contagious infection – such as carriers of the AIDS virus . . . are also individuals with handicaps under the [Rehabilitation Act]."

ix. Even If HIV is Not Always a Disability, The Court of Appeals Correctly Ruled In This Case That Sidney Abbott is Substantially Limited in the Major Life Activity of Reproduction.

Due to her HIV infection, Ms. Abbott is an individual with a disability under the ADA. Because petitioner disputed her disability, Ms. Abbott chose to make an individualized showing in the record that her HIV substantially limited her major life activity of procreation. This Court did not grant certiorari on the Court of Appeals' ruling that Ms. Abbott demonstrated a substantial limitation to procreation. *See* 107 F.3d at 942 (14a-15a). Therefore, if this Court agrees that procreation is a major life activity, it necessarily follows that Ms. Abbott has a disability within the meaning of the ADA.

C. EVEN IF ALL PEOPLE WITH HIV ARE NOT PROTECTED UNDER THE FIRST PRONG OF THE DEFINITION OF DISABILITY, MS. ABBOTT, AS A PERSON DENIED SERVICES BECAUSE OF A COVERED ENTITY'S FEAR OF HER CONTAGION, IS COVERED UNDER THE THIRD PRONG.

The third prong of the ADA's definition of disability covers individuals who are "regarded as having such an

impairment." 42 U.S.C. Section 12102(2). This definition is satisfied where, as here, an individual is denied services solely because of a covered entity's fears about her impairment. *See Arline*, 480 U.S. at 280, 282-283 (substantial limitation based on negative attitudes of others); *see also*, 28 C.F.R. Section 36.104 (same).

Congress added the "regarded as" prong in 1974 to address discrimination due to stereotypical attitudes and ignorance of impairments. *See* p. 8, *supra*. In *Arline*, this Court addressed the scope of this prong in the context of, as in this case, a covered entity's concerns about contagiousness. The Court adopted as an alternative holding that a schoolteacher with tuberculosis was "regarded as" having "such" an impairment when she was fired due to her contagiousness. 480 U.S. at 282-284. The Court declared that "the basic purpose of Section 504 . . . is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others." 480 U.S. at 284. The Court recognized that contagious conditions are almost always accompanied by social stigma. *See* 480 U.S. at 284 ("[f]ew aspects of handicap give rise to the same level of public fear and misapprehension as contagiousness."). The Court specifically observed that the inclusion of "cosmetic disfigurement" in the regulation's definition of "impairment" supported the conclusion that the statute covers limitations caused by stereotypical attitudes about an impairment. 480 U.S. at 283 n.10. "Such an impairment might not diminish a person's physical or mental capabilities, but could nevertheless substantially limit that person's ability to work as a result of the negative reactions of others to the impairment." *Id.* at 283.

The House and Senate Committee Reports on the ADA expressly adopted *Arline*'s analysis of the "regarded as" test. *See* H. Rep – 2 at 53; H. Rep. – 3 at 30; S. Rep. at 23-24. The principle of stare decisis carries particular weight where Congress explicitly endorses the reasoning

of a case. *See Neal v. United States*, 516 U.S. 284, 295 (1996) (noting that this Court gives "great weight to stare decisis in the area of statutory construction . . . [because] 'Congress is free to change this Court's interpretation of its legislation' ") (*quoting Illinois Brick Co. v. Illinois*, 431 U.S. 720, 736 (1977)).

In addition, the Committee reports adopted the regulatory definition of "regarded as" under the Rehabilitation Act. Under these regulations, a person is regarded as having an impairment if he or she:

> (A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by the [covered entity] as constituting such a limitation;
>
> (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or
>
> (C) [does not have an impairment but] is treated by the [covered entity] as having such impairment.

See H. Rep. – 3 at 29, citing 45 C.F.R. Section 84.3(j)(2)(iv); H. Rep. – 2 at 53; S. Rep. at 23.

The legislative history to the ADA makes clear that a person is protected under the "regarded as" prong of the definition of disability if he or she is excluded from any "basic life activity, or is otherwise discriminated against, because of a covered entity's negative attitudes towards that person's impairment . . . " H. Rep. – 2 at 53. The House Judiciary Committee Report emphasized that there are a variety of "myths, fears and stereotypes associated with disabilities" and "attitudinal barriers" which result in discriminatory treatment of persons with impairments. H. Rep. – 3 at 30. These include "concerns regarding productivity, safety, insurance, liability, attendance . . . and acceptance by co-workers and customers." *Id.*

The Senate Report noted that the "regarded as" prong is "particularly important" for persons with "stigmatic" conditions, such as a person with severe burns. S. Rep. at 24. This makes clear that the "regarded as" prong is intended to prohibit discrimination against persons who have impairments which invoke fear and discomfort in others.

The "regarded as" prong is particularly applicable to people with HIV, symptomatic or asymptomatic. The Department of Justice Title III regulation adopts the same definition of "regarded as" as the committee reports and Rehabilitation Act regulations, including when an individual has a "physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others towards such impairment." 28 C.F.R. Section 36.104(4).

HIV is the quintessential stigmatic condition which has engendered fear of contagion, particularly with regard to medical or dental services. *See* n.31, *supra*. As the American Medical Association has noted, "[a]n HIV-seropositive individual . . . may be subject to many and varied discriminations – by family and loved ones, neighbors and friends, employers and fellow employees, and other providers and services."[45] *See also*, New England Journal of Medicine, n.3, *supra*.

Numerous courts have recognized the deeply rooted stigma associated with HIV. *See Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994) (noting that disclosure of HIV status could subject an individual to social ostracism and discrimination in employment, insurance and health care); *Severino v. North Fort Myers Fire Control District*, 935 F.2d 1179, 1182 n.4 (11th Cir. 1991) (finding that HIV-

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[45] *See* American Medical Association, Board of Trustees Report, Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report, 258 Journal of the American Medical Association No. 15, October 16, 1987, 2097, 2098.

positive firefighter was "regarded as" handicapped and noting that the "contagiousness of the disease brings AIDS within the definition of handicap"); *Support Ministries v. Village of Waterford, N.Y.*, 808 F. Supp. at 132 ("individuals with asymptomatic HIV were substantially limited in major life activities due to the prejudice and apprehension AIDS engenders on a social level"); *Cain v. Hyatt*, 734 F. Supp. at 680 ("[t]he pervasive anxiety that AIDS is easily transmitted converges with and often ostensibly justifies the disapprobation of AIDS victims").[46]

It is undisputed that Ms. Abbott was denied services in a place of public accommodation due solely to fears of contagion. As a result, Ms. Abbott is a person who is "regarded as" having a physical impairment and therefore, is for this additional, alternative reason, a person with a disability under the statute.

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[46] Some courts have held that "regarded as" applies when a covered entity erroneously believed that an individual had an impairment which substantially limits major life activities. *See, e.g., Aucutt v. Six Flags Over Mid-America, Inc.*, 85 F.3d 1311, 1319 (8th Cir. 1996). These cases, however, have been decided under the third section of the regulatory definition of "regarded as," which focuses on a covered entity's misperception that an individual had an impairment which was substantially limiting. *See Aucutt*, 85 F.3d at 1319 (noting that there is no evidence that the employer "perceived or treated" employee as having a substantially limiting impairment). These decisions have not involved stigmatic conditions such as HIV, which are covered under the second section of the regulatory definition, referring to impairments that, in fact, substantially limit major life activities as a result of the attitudes of others toward the impairment. *See* 28 C.F.R. Section 36.104; 29 C.F.R. Section 1630.2(1)(2).

II. COURTS SHOULD DEFER TO PUBLIC HEALTH AUTHORITIES – NOT NON-SPECIALISTS, SUCH AS A GENERAL DENTIST – TO DETERMINE WHETHER THE RISK OF TRANSMISSION OF AN INFECTIOUS DISEASE JUSTIFIES DISCRIMINATION AGAINST A PATIENT.

A. The *Arline* Decision, the ADA's Legislative History, and Agency Regulations Require That the Determination of "Direct Threat" be Made With Deference to Public Health Authorities, Not to Public Accommodations.

Although the American Dental Association insists that patients with HIV may be safely treated in a private dental office, petitioner argued below that such treatment would pose a "direct threat to the health or safety of others." 42 U.S.C. Section 12182(b)(3). In making this argument, petitioner contends that the Court should defer to his own personal beliefs as long as they are "reasonable." Petitioner's Brief at 15.[47] Petitioner's position contravenes this Court's opinion in *Arline*, as well as the ADA legislative history and Title III Regulations.

In *Arline*, this Court established an objective test to determine whether discrimination is justified by a "direct threat" defense.[48] The Court stated twice for emphasis

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[47] Petitioner claims that he should not be liable if he acted in "good faith." Petitioner's Brief at 15. Petitioner confuses whether he should be liable as a matter of tort law with whether he should be enjoined from violating a federal anti-discrimination statute.

[48] This Court instructed trial courts to make findings of fact "based on reasonable medical judgment given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long the carrier is infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the

that in making this determination, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288; *see also*, 480 U.S. at 286 n.15;[49] *American Dental Ass'n v. Martin*, 984 F.2d 823, 828 (7th Cir. 1992) ("judgments of the [United States Centers for Disease Control and Prevention[50]] are entitled to respect"), *cert. denied*, 510 U.S. 859 (1993); *id.* at 832 (Coffey, J., concurring) (the CDC is medically and scientifically qualified to determine and evaluate if there is in fact a significant risk in the health care arena); *Chalk v. United States District Court*, 840 F.2d 701, 706-708 (9th Cir. 1988) (noting that *Arline* "admonishes" courts to defer to public health officials and crediting the position of the CDC, Surgeon General and American Medical Association).

In codifying the "direct threat" defense into the ADA, Congress expressly adopted the full *Arline* test. *See* H. Rep. – 3 at 34, 45 ("the Committee intends to codify the 'direct threat' standard used by the Supreme Court [in *Arline*]"; the "risk of transmitting the infection to others must be determined based on objective and accepted public health guidelines."); H. Rep. – 2 at 76 ("the term 'direct threat' is meant to connote the full standard set forth in *Arline*"); S. Rep. at 27.

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disease will be transmitted and will cause varying degrees of harm." 480 U.S. at 288.

[49] Petitioner's "direct threat" defense focuses exclusively on fears about his own safety, not the best interests of the patient. This case therefore does not present the question how a court should weigh a physician's judgment about the most appropriate medical treatment or care for the patient.

[50] The Centers for Disease Control and Prevention (CDC) is a federal agency which is the preeminent public health authority in the United States. Its mission is to investigate and monitor health problems and develop sound policies and strategies for the prevention and control of diseases. J.A. 103.

The Department of Justice Title III regulation similarly codifies *Arline*. 28 C.F.R. Section 36.208; 28 C.F.R. part 36, App. B Section 36.208. In the Appendix to these Regulations, the Department of Justice explains that the test is an objective one and that the Department expressly rejected proposals to permit a public accommodation to exercise its own judgment to determine a "direct threat." 28 C.F.R. part 36, App. B Section 36.208. These regulations are controlling unless they can be shown to be arbitrary, capricious or contrary to the statute which petitioner has not demonstrated. *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984); *Equal Employment Opportunity Commission v. Commercial Office Products Company*, 486 U.S. 107, 124 (1988) (O'Connor, J., concurring).[51]

B. Deference to Public Health Authorities is Essential to Achieve the Statute's Goals of Protecting the Public Health While Eradicating Unwarranted Discrimination.

In enacting the ADA, Congress was not unmindful that in certain situations contagious diseases could pose a health risk to others. At the same time, Congress understood that contagious diseases have historically been subject to myths, fears and stereotypes. *See Arline*, 480 U.S. at

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[51] The regulations add that a direct threat is "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies. . . . " 28 C.F.R. Section 36.208. Courts applying the "direct threat" defense under Title III have followed the regulations and shown deference to public health authorities. *See, e.g., United States v. Morvant*, 898 F. Supp. at 1166-1167 (rejecting "direct threat" argument and noting "plethora of expert testimony" including from the CDC that its guidelines significantly mitigate any risk). In no case concerning a contagious disease has a court ever deferred to a defendant's personal beliefs.

284 & n.12 (noting the "complex and often pernicious mythologies about . . . the transmission of illness . . . "; "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.").[52] The "direct threat" test aims to "protect[ ] handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposing others to significant health and safety risks." *Arline*, 480 U.S. at 287.

Deference to public accommodations, including health care providers, would destroy this balance because health care providers are as susceptible as anyone else to the fears and stereotypes which accompany contagious diseases. *See* n.31, *supra*. Indeed, the statute explicitly includes the offices of health care providers in the list of public accommodations. *See* 42 U.S.C. Section 12181(7)(F). Congress must have believed that health care providers could engage in unwarranted discrimination against patients. In addition, health care providers are not held to a different standard with respect to "direct threat" than any other place of public accommodation, such as a hotel, restaurant, grocery store, or day care center.

Moreover, assessing the risk of transmission of infectious diseases requires expertise in epidemiology and microbiology beyond the scope of public accommodations, including health care providers. In particular, petitioner, a general dentist, does not have medical training or expertise in the transmission of infectious diseases

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[52] *See also*, H. Rep. – 3 at 45 ("person with disability must not be excluded . . . based on stereotypes or fear . . . [or] speculation about the risk or harm to others"); S. Rep. at 27 ("direct threat" cannot be based on a "speculative or remote risk").

such as HIV.[53] Petitioner has not had any formal dental or medical training since his graduation from dental school in 1978, when infection control was not a "specific topic at that time." Motion, p. 2 and n.2.[54] He testified under oath that he is not an expert in the epidemiology or modes of transmission of HIV (Motion, p. 4) and has never had any training in microbiology, epidemiology, virology or infectious diseases. Motion, pp. 2-4. Sanford Kuvin, M.D., petitioner's sole expert in this case, testified that he does not believe that petitioner is an expert on infection control.[55] Petitioner specifically represented to the trial court that he was not an expert on infectious diseases for purposes of summary judgment in this case. J.A. 261. Petitioner may have special knowledge about filling a cavity, but he has no specialized knowledge about the relevant issue in this case: the risk of HIV transmission.

C. Petitioner's Argument That Courts Should Defer to Him Misconstrues the Clear Legal Precedent and the ADA's Statutory Goals.

In arguing that the lower court should have deferred to his own good faith and subjective assessment of

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[53] *See* Plaintiff's Memorandum in Support of Motion to Exclude Expert Report and Testimony of Randon Bragdon, D.M.D, District Court Docket No. 61, dated September 19, 1995 (hereinafter, the "Motion"), and Reply Memorandum, District Court Docket No. 87.

[54] Petitioner states that he has taken numerous continuing education courses relating to HIV and infection control. He did not provide any evidence that any of these general courses for nonexperts stated that it is unsafe to provide routine dental care to patients with HIV in a private dental office.

[55] *See* Deposition of Sanford Kuvin, M.D. (p. 223), District Court Docket No. 58.

"direct threat" (*see* Brief at 15),[56] petitioner ignores the clear language of the regulations, as well as the legislative history and this Court's opinion in *Arline*. Petitioner quotes *Arline* out of context as stating that it "does not address whether courts should defer to reasonable medical judgments of private physicians." Petitioner's Brief at 44. *Arline* actually states that it does not address "whether courts should also defer to the reasonable medical judgments of private physicians *on which an employer has relied*." 480 U.S. at 288 n.18 (emphasis supplied). *Arline* does not contemplate that a lower court would ever defer to the judgment of the defendant. This case does not raise the issue which *Arline* left open. It is undisputed that at the time Dr. Bragdon refused to fill Sidney Abbott's cavity, he did not consult or seek guidance from anyone.

Petitioner also quotes out of context one sentence of the Senate Committee report that "nothing in this legislation is intended to prohibit a physician from providing the most appropriate medical treatment in the physician's judgment." Petition at 43. The prior sentences state:

> . . . A physician who specializes in treating burn victims could not refuse to treat the burns of a deaf person because of his or her deafness. However, such a physician need not treat the deaf individual if he or she does not have burns nor need the physician provide other types of

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[56] Petitioner's position on the third question presented is completely circular. He frames the issue as whether courts should defer to his judgment *as long as* it is reasonable in light of then-current medical knowledge. This begs the question: How should a court determine what is reasonable in light of current medical knowledge? *Arline*, the ADA's legislative history and the agency regulations direct courts to public health authorities.

> medical treatment to individuals with disabilities unless he or she provides other types of medical treatment to nondisabled individuals.

S. Rep. at 62-63. This clarifies that physicians are not required to provide treatment outside their scope of services or specialization. In this case, however, petitioner acknowledged that he regularly fills cavities and was competent to fill Ms. Abbott's cavity.[57] Petitioner's sole reason for refusing to treat Ms. Abbott was his fears about his own safety, not concerns about appropriate treatment for the patient.[58]

Finally, petitioner cites cases which concern the limits on state authority under the Fourteenth Amendment. These cases say nothing about how a federal statute should be interpreted. For example, in *Youngberg v. Romeo*, 457 U.S. 307 (1982), this Court addressed the Constitutional limitations on the state, acting in *parens patriae*, when confining a person involuntarily committed to an institution for the retarded. The deference to the judgments of professionals at the institution was based in part on the interest in minimizing judicial interference with the operations of state institutions. *See* 457 U.S. at 320-323.[59] If anything, this case supports deference to

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[57] *See* Deposition of Randon Bragdon, D.M.D., District Court Docket No. 58, pp. 272-273 (acknowledging that if Ms. Abbott had not indicated that she was HIV-positive, petitioner would have filled her cavity in his office).

[58] It is undisputed that Ms. Abbott required a filling and that petitioner did not deny her treatment on any grounds related to her dental or medical needs. Thus, the issue before the Court is not whether any deference is appropriate to health care providers when they are assessing what treatments are appropriate for patients.

[59] The Court in *Youngberg* also ruled that decisions about patient care must be made by a professional who is "competent, whether by education, training or experience, to make the

public health authorities, not deference to the judgments of individual providers.

Ultimately, by citing these due process cases and seeking "space for civil liberty among dentists" (Petitioner's Brief at 50), petitioner is arguing that the ADA incorrectly prohibits him from discriminating where he believes he should be free to do so.[60] It goes without saying that it is the Court's task to interpret the statute, "not to second-guess the wisdom of the congressional policy choice." *Mansell v. Mansell*, 490 U.S. 581, 594 (1989).

Even if this Court were to grant deference to the beliefs of individual health care providers, there is no basis to disturb the Court of Appeals' affirmance of summary judgment in favor of Ms. Abbott. Both the District Court and the Court of Appeals scrutinized the voluminous evidence presented by petitioner in support of his "direct threat" defense and found it to be nothing more than "conjecture," "speculation" and "tangential statistics." 980 F. Supp. at 588-589 (43a-47a); 107 F.3d at 946-948 (24a-30a).

CONCLUSION

The Court of Appeals correctly found that Ms. Abbott is an individual with a disability and that petitioner unlawfully discriminated against her. If it is uncertain whether an individual with HIV has a disability, or if public accommodations can rely on their own fears and

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particular decision at issue." *Id.* at 323 n.30. Public accommodations, such as petitioner in particular, do not have the training, experience or education to assess the risk of transmission of infectious diseases.

[60] The district court rejected petitioner's challenge to the constitutionality of the ADA. *See* 912 F. Supp. at 592-595 (54a-62a). Petitioner did not appeal that ruling.

conjecture to discriminate, then any hospital could lawfully refuse to draw blood or insert an intravenous line in any patient with HIV. The result would be a medical disaster for the almost one million people in this country living with HIV and a public health disaster for society in general.

The judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

BENNETT H. KLEIN
Counsel of Record
GAY & LESBIAN ADVOCATES
& DEFENDERS
294 Washington Street, Suite 740
Boston, MA 02108-4608
(617) 426-1350

WENDY E. PARMET
Northeastern University School
of Law
400 Huntington Avenue
Boston, MA 02115
(617) 373-2019

Counsel for Respondent
Sidney Abbott

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In The

SUPREME COURT OF THE UNITED STATES

October Term, 1997

RANDON BRAGDON, D.M.D.

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

REPLY BRIEF FOR THE PETITIONER

JOHN W. McCARTHY
Counsel of Record
BRENT A. SINGER, Ph.D.
RUDMAN & WINCHELL, LLC
Attorneys for Petitioner
84 Harlow Street
Bangor, Maine 04401
Telephone: (207)947-4501

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I. IF DR. BRAGDON'S RISK ASSESSMENT WAS WITHIN THE RANGE OF REASON GIVEN THEN-CURRENT MEDICAL KNOWLEDGE, HE SHOULD NOT BE LIABLE.

Respondents and *amici* ("Abbott") seem to concede that if Dr. Bragdon's risk assessment was within the range of reason given then-current medical knowledge, then Dr. Bragdon should not be liable.[1] Their concession is implicit in their refusal to join the issue, attacking instead caricatures of Dr. Bragdon's position.[2] The lower courts, however, did not apply the standard for healthcare provider liability under title III urged by Dr. Bragdon. Instead, each applied a legal presumption that required him to do significantly more to survive summary judgment than raise a genuine issue of whether his risk assessment was within the range of reason given then-current medical knowledge. If it was error to apply these presumptions, the case should be remanded for the application of the correct standard.

Furthermore, Dr. Bragdon is *not* arguing courts should defer to individual dentists because they are experts.[3] The term "deference" can be

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[1] The American Medical Association (AMA) expressly concedes that dentists "need do no more—and no less—than make a medically reasonable decision . . . ." AMA Br. at 25.

[2] Resp't Br. at 42, 46-47, 49 (characterizing Dr. Bragdon's position as seeking deference to subjective, personal beliefs, *simpliciter);* Infectious Diseases Soc. of Am., et al., Br. at 23 (same); AIDS Action Council, et al., Br. at 28 (same).

[3] Dr. Bragdon did designate himself as an expert for trial. Abbott objected under Rule 702, and Dr. Bragdon responded that his training and experience as a dentist for 17 years qualified him under Rule 702 to give testimony on numerous issues. For summary judgment purposes, however, Dr. Bragdon did not claim that his own personal opinions are evidence of the objective range of reason, and the District

misleading. Dr. Bragdon is not asking the Court to defer to anybody or to decide ultimately whether there is a significant risk. The legal question for the Court is when may a dentist be liable for discrimination under the ADA. Dr. Bragdon's view is that (1) if a reasonable dentist could have concluded from then-current medical knowledge that the risk was significant, and (2) if he thought in good faith that the risk was significant, then he did not violate Ms. Abbott's civil rights.

It is also important to understand that although the quantification of a risk can be mostly objective and scientific, to decide whether it is "significant" requires a value judgment informed by political, policy, or even personal factors.[4] Very low identifiable risks that are difficult to estimate are often "significant" for health policy reasons,[5]

Court never ruled on Abbott's Rule 702 objection.

[4] *See* Barry Sullivan, *When The Environment Is Other People: An Essay On Science, Culture, and the Authoritative Allocation of Values*, 69 Notre Dame L. Rev. 597, 601, 643 (1994) (the "standard formulation of the [*Arline*] 'significant risk' test represents a[n] . . . attempt to fit normative pegs into factual holes").

[5] OSHA treats the "Klein study," cited by Infectious Diseases Soc. of Am., et al. Br. at 20 n.10, as evidence of a significant risk to dentists, though it found only one apparent occupational HIV infection among 1,132 dentists. 56 Fed. Reg. 64004, 64092 (Dec. 6, 1991) (Pet. App. 83a-84a). The estimated risk of HIV infection following *just one* percutaneous occupational exposure to HIV is 0.3%, or 3 expected fatalities per 1000 exposed, which is *three times* the level of risk deemed "significant" by the Court in *Industrial Union Dep't, AFL-CIO v. American Petroleum Inst.*, 448 U.S. 606, 655 (1980) (plurality). Health officials thought the risk of developing Guillain-Barre syndrome for vaccinees was significant, even though it was less than 1 in 100,000. Richard Neustadt & Harvey Fineberg, *The Swine Flu Affair* 69-73 (1978); Arthur Silverstein, *Pure Politics and Impure Science: The Swine Flu Affair* 117-119 (1981). Dr. Bragdon

and reasonable individuals may have differing personal risk tolerances.

By affidavits of Dr. Marianos, the CDC reached an implicit policy decision that the known risk to dentists (for no one denies there is a risk) is insignificant.[6] The CDC disclosed this position for the first time in private civil litigation, which came to Dr. Bragdon's attention when he obtained a copy of Dr. Marianos's January 7, 1995, affidavit filed in *United States v. Morvant*, 898 F. Supp. 1157 (E.D. La. 1995). Various other organizations now maintain in an amicus brief that the risk is "negligible" (Infectious Diseases Soc. of Am., et al., Br. at 19-22).[7] These decisions have not been "the product of open and complete analysis," relevant dimensions of the problem have been "suppressed without explanation," Sullivan, *supra*, note 4, at 664, and the lower courts have tried to resolve issues "without acknowledging their normative

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was keenly aware of these policy precedents. In addition, while Ms. Abbott offered her opinion that taking penicillin is "considered safe" (Mot. for S.J. at 16, filed Sept. 19, 1995), the article relied on by her expert states that the incidence of adverse reactions to penicillin is a "*significant* health problem." John Erffmeyer, *Adverse Reactions to Penicillin*, 47 Ann. Int. Med. 288, 288 (1981) (Ex. E of Sept 13, 1995 Aff. of Donald Craven, M.D.)(emphasis added).

[6] The policy directive is implicit to the extent Dr. Marianos avoids using the term "insignificant." The locution he prefers, which first appears in his *fourth* declaration (J.A. 283), is that "it is *safe* to provide routine dental care to patients with HIV . . . when universal precautions are utilized." Dr. Marianos understands, however, that the intended result of his testimony is the establishment into federal law of the policy that the risk is insignificant.

[7] *But see* Carol Chenoweth, et al., *Postexposure Chemoprophylaxis for Occupational Exposure to HIV in the Dental Office*, 128 JADA 1135, 1136 (Aug. 1997) (**occupational HIV risk to dentists characterized as "low," not negligible**, and stressing need for HIV postexposure plans).

character" by deferring to the CDC which has "no mandate to resolve normative issues." *Id.* at 685.[8]

Nevertheless, according to Abbott (U.S. Br. at 26), the best thing the Court can do is to follow the advice in *Chalk v. United States Dist. Ct.*, 840 F.2d 701, 712 (9th Cir. 1988) (Sneed, J., concurring):

> Confronted with some uncertainties about scientific truth, judges, perhaps above all others, should act on the basis of that which is known, or, where this is not possible, on the basis of that which those best qualified to speak say is known. . . . [W]e have no choice but to accept their version of the truth.

The fallacy here is the assumption that the Court should or must accept anyone's version of the truth as to whether there is a "significant risk." The proper role of the Court is not final arbiter of substantive national health policy, acting on its own or in conjunction with the AMA or CDC. Even if Professor Sullivan's ideal agency existed, the agency's policies could have the force of law only by express Congressional delegation, not judicial fiat. The limited role of the judiciary is to decide if Dr. Bragdon committed a civil rights violation. The Court can best advance this goal by remanding for

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[8] Professor Sullivan's makes many good points, but his critical theme is belied by his own uncritical, unspoken, and unsupported assumption that if his ideal, democratically accountable agency of experts considered all the scientific and normative issues involved, it would naturally decide the risk of occupational HIV transmission is insignificant. Professor Sullivan also wrongly assumes that the burden of proof on "direct threat" is on defendants. *See E.E.O.C. v. Amego, Inc.*, 110 F.3d 135, 143 (1st Cir. 1997).

application of the legal standard urged by Dr. Bragdon, which does not require any court to set substantive national health policy.[9]

II. DR. BRAGDON'S RISK ASSESSMENT WAS WITHIN THE RANGE OF REASON GIVEN THEN-CURRENT MEDICAL KNOWLEDGE.

Abbott asks the Court to find that on September 16, 1994 (1) there was a "consensus among public and private health authorities that [filling Ms. Abbott's cavity] posed no significant risk of harm to Dr. Bragdon if universal precautions were followed" (AMA Br. at 27); (2) Dr. Bragdon knew or should have known of such a consensus; and (3) no dentist could have reasonably assessed the risk differently. The record supports none of these findings, and certainly not the absence of disputed fact required for summary judgment.[10] As to relevant facts and inferences therefrom, please see pages 12-25 of Dr. Bragdon's petition reproduced in the appendix hereto.[11] Dr. Bragdon also wishes to highlight three additional points.

First, Abbott offers only two pieces of evidence that Dr. Bragdon knew or should have known of a private and public consensus as to the significance

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[9] The Maine Human Rights Commission (MHRC) misstates Justice Department guidelines concerning "direct threat." *Compare* MHRC Br. at 4 *with* 56 Fed. Reg. 35544, 35560 (July 26, 1991), *reprinted at* 28 C.F.R. pt. 36 app. B § 208.

[10] Even if officials had made it known there was a consensus (which they did not), does the mere announcement define the boundaries of reasonable risk assessment? If not, what analysis must health officials provide before courts should close the legal door on the possibility that a private person could reasonably disagree?

[11] By joining these issues, Dr. Bragdon does not concede the Court should reach them. (*See* Pet. Br. at 10-11)

of the risk: (1) the 1993 CDC guidelines on infection control for dentists (Pet. App. 181a-199a), and (2) the American Dental Association's (AmDA's) 1991 policy statement:

> Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.

(J.A. 225) The language in the 1993 CDC guidelines does not support Abbott's conclusion (*see* Pet. at 21-22). The language in the AmDA's policy statement is non-committal at best. To say that procedures provide protection and something may be done safely with proper precautions does not mean the risk is insignificant. Brain surgery may be done safely with proper precautions.

Furthermore, the contemporaneous opinion of the American Association of Orthodontists was that in health care settings "scientific evidence indicates that HIV disease poses a direct threat and significant risk" and "much uncertainty surrounds what precautions, including barrier techniques, if any, can prevent the transmission of HIV disease."[12]

Consider too the 1992 FDA guidelines to blood banks. (Pet. App. 97a) If Dr. Bragdon had contact with the blood of *any* patient in the preceding year because of a sharps or needlestick injury (which

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[12] Comment No. 863 at 5 (April 23, 1991) in ADA Comment Book #1 for Public Inspection, available through Justice Department, disability rights division, 4th floor, 1425 New York Ave. N.W., Washington, D.C.

always occurs more than once a year), and the blood bank followed the FDA guidelines, it would regard Dr. Bragdon as if he had HIV and not permit him to donate blood. According to Abbott this would make him disabled under the ADA (i.e., regarded as having HIV). If Dr. Bragdon sued the blood bank under title III, and it said he posed a direct threat, what result? Based on FDA guidelines, could no reasonable blood bank think the risk to dentists was significant? And if the blood bank may deem the risk significant, why not the dentist himself? Also, if the consensus was that the risk is negligible with universal precautions, why does OSHA mandate extensive and expensive *post-exposure* HIV testing and prophylaxis procedures for dental offices? *See* 29 C.F.R. § 1910.1030(f)(3)(ii)-(vi); 56 Fed. Reg. at 64064-65 (noting the "relatively high frequency of occurrence of exposure incidents" in the dental office).[13]

Second, Abbott's substantive analysis is essentially predicated on one sentence: The CDC has never documented a case of occupational transmission of HIV to a dentist. To maintain this argument, Abbott overlooks the CDC's warning

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[13] OSHA said available information was insufficient to estimate the effectiveness of universal precautions (UPs) in reducing occupational HIV infection. 56 Fed. Reg. at 64055. As for hepatitis B virus (HBV), OSHA estimated that UPs were only 75% effective, *id.* at 64058, and concluded that UPs are insufficient to provide the level of workplace safety mandated by law, *id.* at 64088. *See also* M.A. Noble, et al., *Hepatitis B and HIV Infections in Dental Professionals*, 57 J. Can. Dent. Assoc. 55, 55 (1991) ("use of gloves did not show a protective effect" and "[r]eliance on gloves for operator protection appears to be inadequate"). Like HIV, HBV is a bloodborne pathogen. Although HIV is about 100 times less infectious than HBV, HIV is more than 50 times as deadly. 56 Fed. Reg. at 64009 and J.A. 179.

that its figures "most likely [do] not reflect the full extent of occupational transmission" (Pet. App. 105a). She also discounts seven HIV-infected dental workers who had occupational exposures to HIV, and who "have been investigated and are without identifiable [non-occupational] behavioral or transfusion risks" (Pet. App. 111a n.3, 110a, 106a) (e.g., AMA Br. at 11-12). Abbott's handling of these dental workers illustrates the principle that "risk assessors make constitutive value judgments whenever they follow one methodological rule rather than another." Sullivan, *supra*, note 4, at 650. More concretely, Dr. Marianos's testimony that "it is likely that a number of [the seven dental workers] . . . actually had nonoccupational risk factors . . . they did not report or recognize" (U.S. Reply Mem. on S.J., Ex. A ¶ 5), shows that his value system leads him to speculate that all seven were infected while they or others carried on illicit sexual affairs or drug use hidden from CDC investigators.[14]

Third, Abbott never objected to the admissibility of Dr. Kuvin's expert testimony, unlike disputed expert testimony in *General Electric v. Joiner*, 118 S. Ct. 512 (1997). Without ruling it inadmissible, the Appeals Court tried to discount Dr. Kuvin's testimony because it relies

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[14] The Court must appreciate Dr. Bragdon's profound frustration when courts belittle his evidence as "conjecture" (even his direct observations of how often he sustains accidental sharps injuries! -- *see* Pet. App. 28a), and treat the sketchiest of public health official affidavits as gospel. Abbott also implies that the law expects dentists to take greater risks than patients or other citizens. This moral principle has never been part of our jurisprudence, and certainly not for elective, non-emergency treatment. *See, e.g., Le Juene Road Hosp., Inc. v. Watson*, 171 So.2d 202, 203 (Fla. App. 1965); *see also* 42 U.S.C. § 1395dd.

partly on post-September 1994 authority. But most of Dr. Kuvin's authorities pre-date September 1994.[15] Moreover, no one argues that anything happened after September 1994 to make it reasonable to assess the risk as significant when before it was not. Dr. Kuvin's opinion is plain that both before and after September 1994 Dr. Bragdon could have reasonably assessed the risk as significant. Dr. Kuvin's testimony, by itself and with the primary authorities cited by Dr. Bragdon, raises a genuine issue of whether Dr. Bragdon's risk assessment was within the range of reason given then-current medical knowledge. Weighing this evidence belongs to the fact finder at trial.[16]

III. DR. BRAGDON DID NOT REGARD MS. ABBOTT AS DISABLED.

Abbott makes two arguments under the third prong, 42 U.S.C. § 12102(2)(C), whereby a person

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[15] *See* Def.'s Rule 19 Statement of Undisputed Mat'l Facts, Ex. C; Second Decl. of Sanford F. Kuvin, M.S., M.D., D.T.M. & H. The reason no attempt was made in the District Court to divide Dr. Kuvin's opinions by the date of authority relied upon is that Dr. Bragdon proceeded as though the fact finder had to decide whether there is a direct threat. Dr. Bragdon argued on appeal for a standard based on reasonable judgment and then-current medical knowledge. The Appeals Court reached this issue over Ms. Abbott's objection.

[16] Filling cavities, which entails giving oral injections to nervous patients, working in bloody aerosol mists (Pet. App. 69a-70a), and poking with sharp instruments in bloody mouths, is a long way from the classroom setting, *cf. Thomas v. Atascadero Unified Sch. Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987), and more like instruction in hard-style karate where "students frequently receive nosebleeds and minor cuts." *Montalvo v. Radcliffe*, No. 3:97cv487, Findings of Fact and Conclusions of Law at 2 (U.S. Dist. Ct. E.D. Va. Jan. 29, 1998) (finding that HIV-infected student posed direct threat to others in karate class).

is "disabled" if she is regarded as "having *such* an impairment" (emphasis added), meaning an impairment "that substantially limits one or more major life activities," 42 U.S.C. § 12102(2)(A).

The first is that she "is a person who is 'regarded as' having a physical impairment and therefore . . . a person with a disability under the statute." (Resp't Br. at 41) According to this argument, merely to regard an individual as having a physical impairment makes the individual disabled under the ADA. This eliminates from the inquiry the qualifying phrase "that substantially limits one or more major life activities."

The ADA's definition of "physical impairment" is extraordinarily broad. *See* 28 C.F.R. § 36.104 (physical impairment means "*Any* physiological disorder *or condition*, *cosmetic disfigurement*, or anatomical loss affecting one or more of the following body systems: [comprehensive list of all body systems]") (emphasis added). For Abbott, then, if a defendant regards someone as having a physical impairment (e.g., an infected finger or sprained ankle), the person is "disabled" under the ADA. This is over broad. *See* 56 Fed. Reg. at 35549, *reprinted at* 28 C.F.R. pt. 36 app. B § 104 ("simple infected fingers" are not disabilities, and "broken legs" are rarely regarded as disabilities). As the Justice Department explains, "Test C--Being Regarded as Having Such an Impairment" is intended to cover "persons who are treated . . . as having a physical or mental impairment *that substantially limits a major life activity.*" *Id.* at 35549-35550 (emphasis added).

Abbott also makes the somewhat narrower argument that for certain stigmatizing impairments, defined as those "which invoke fear and discomfort in others" (Resp't Br. at 40), a person is disabled when a defendant treats her

unreasonably out of unfounded fear, prejudice, attitudinal barriers, or the like. The essence of this argument is that whenever a defendant employer or public accommodation treats someone unreasonably based on exaggerated fears or discomfort concerning any impairment, the defendant, by virtue of that very act, *both* constitutes the person as having a stigmatizing disability and discriminates against her in violation of the ADA. This argument not only eliminates the inquiry into substantial limitation on a major life activity, but also collapses the distinction between determining (a) whether someone is disabled and (b) whether there was unlawful discrimination: an unreasonable reaction based on an impairment makes the plaintiff disabled and violates the ADA.[17]

This is an interesting theory, but even the Court's broadly worded dicta in *Arline* seems to recognize that the third prong is not satisfied for "those who are [merely] regarded as impaired," unless "as a result, [they] are substantially limited in a major life activity." *Arline*, 480 U.S. at 284; *see also* S. Rep. No. 93-1297, 93rd Cong., 1st Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 6373, 6414 (the new definition "focuses on substantial limitations of one or more of an individual's major life activities" and includes "an individual who is *regarded* as having such a substantial limitation"). This is sensible since otherwise the ADA would be transformed from the Americans with Disabilities Act into the "Act to Outlaw All Unreasonable Fears Based on Physical or Mental Impairments."

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[17] Here, contrary to Abbott's assurances, "the breadth of the definition [of disability]" is *not* "balanced by the limiting or restrictive principles in the substantive discrimination provisions." (Resp't Br. at 16 n.19)

The AMA implicitly recognizes that Abbott's arguments have no basis in the statute. The AMA therefore makes the novel argument that Dr. Bragdon regarded Ms. Abbott as substantially limited in the major life activity of caring for herself. Assuming only for the sake of argument that "caring for one's self," 28 C.F.R. § 36.104, includes periodic trips to have cavities filled,[18] the record does not support a finding that Dr. Bragdon's reaction caused Ms. Abbott to be substantially limited in the ability to care for herself, or that Dr. Bragdon perceived her as substantially limited in the ability to care for herself. Rather, Dr. Bragdon testified that when he offered to fill Ms. Abbott's cavity in a hospital, he believed that Eastern Maine Medical Center ("EMMC") "maintained [dental facilities] and general dentistry could be done at that facility without any problem" and EMMC would have been the "first place" he would have looked to if she had accepted his offer (June 5 and 6, 1995 Bragdon Dep. at 286-287, 282-283). EMMC is located less than 1.2 miles from where Ms. Abbott lived in Brewer and less than 1.1 miles from where she worked. (J.A. 48) Dr. Bragdon's office is three times as far away.[19] Dr. Bragdon did not,

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[18] "Caring for one's self" usually refers to *daily* activities such as bathing, dressing, cleaning, cooking, etc. *E.g.*, CDC, *Prevalence of Mobility and Self-Care Disability—United States, 1990*, 42 MMWR 760 (Oct. 8, 1993); *Nicely v. Rice*, 1992 WL 403091, *3 (D. Kan.).

[19] Dr. Bragdon also said he would have considered using St. Joseph Hospital (Bragdon Dep. at 282). St. Joseph is less than a mile from where Ms. Abbott worked. It was only after Ms. Abbott declined his offer that Dr. Bragdon learned that the head of dental services at EMMC and St. Joseph was against the idea of general dentists working in the hospital. (*id.* at 283-85) Thereafter Dr. Bragdon applied at Downeast Community Hospital in Machias for dental privileges, but

therefore, regard Ms. Abbott as substantially limited, or cause her to be substantially limited, in the ability to care for herself.

This evidence is also important because Abbott repeatedly accuses Dr. Bragdon of violating his ethical duty by *refusing* to treat her. Dr. Bragdon never refused to treat her. He decided to treat her, and said he would treat her in a hospital, which he thought would be EMMC. She said she would "think about it and get back to him" (Pet. App. 80a). Instead of responding to him, she sued him. In no way is it fair to depict this as a violation of Dr. Bragdon's ethical duty to treat.[20]

IV. ABBOTT'S INTERPRETATION OF THE TERM "DISABILITY" IS POLICY-DRIVEN, OPEN-ENDED AND NOT BASED ON THE STATUTE.

Dr. Bragdon agrees that the definition of disability is not limited to "traditional handicaps" such as blindness. That is why a person with TB, HIV, malaria, a drug addiction, any form of cancer, or any other "physiological disorder or condition, cosmetic disfigurement, or anatomical loss," 28 C.F.R. § 36.104, may and often will be "disabled" *as long as* that impairment also substantially limits a major life activity, or she has a record of such a limitation, or she is regarded as having

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ironically that failed mostly because Ms. Abbott was suing him and the hospital was worried about its own potential legal exposure. (Def.'s Mot. for S.J. Ex. 6)

[20] Deferral of elective dental and medical treatment to a safer, more controlled, or more convenient time or location is common. *See, e.g.*, James A. Cottone, et al., *Practical Infection Control in Dentistry* 81-82 (2d ed. 1996) (deferral of elective dental treatment whenever there is any reasonable uncertainty surrounding the possibility of active TB). As to more controlled settings, *see also* confidential document lodged with the Court.

such a limitation. This definition was formulated to "provide sufficient latitude (but still not be totally open ended)." S. Rep. No. 93-1297, 93rd Cong., 1st Sess., *reprinted in* 1974 U.S.C.C.A.N. 6373, 6413.

Abbott tries to fit asymptomatic HIV infection into this definition by exaggerating the uniformity of physiological and psychological responses. For some the diagnosis of HIV infection is so devastating psychologically as to substantially limit the ability to learn (e.g., go to school) or work (e.g., clinically depressed). But this is not universal. Physically, five percent of persons with HIV have "remained *clinically healthy* and *immunologically normal* for more than a decade," while the average interval between infection and the development of AIDS is about ten years.[21] Ms. Abbott herself reported that her "general health" was "good" (J.A. 49). When asked whether she was impaired in her ability to carry out *any* of her life functions by the fact she is HIV positive, she said "No" (J.A. 14). Psychologically, some with HIV have "indicated personal growth as a result of having this disease and were firm in their belief that this growth would not have happened without HIV as an impetus."[22] Everyone in one study "described being able to look to the future and acknowledged they are surviving with HIV infection and not waiting to die." Katz, *supra*, note 22, at 54. "Many of these individuals stated they would not change

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[21] Yunzhen Cao, et. al., *Virologic and Immunologic Characterization of Long-Term Survivors of [HIV] Type 1 Infection*, 332 N. Eng. J. Med. 201, 201 (1995) (emphasis added); Mitchell Katz, et al., *HIV Infection*, Current Medical Diagnosis & Treatment 1204, 1208 (1998).

[22] Anne Katz, *Gaining a New Perspective On Life as a Consequence of Uncertainty in HIV Infection*, 7 J. Ass'n of Nurses in AIDS Care 51, 53 (July-August 1996).

anything about their life, even the fact of their HIV infection." *Id.* at 58.[23] Accordingly, even the Justice Department agrees that the determination of whether any particular impairment (e.g., a severe allergy) is a disability "*must* be made using *the same case-by-case analysis* that is applied to *all* other physical or mental impairments." 56 Fed. Reg. at 35549, *reprinted at* 28 C.F.R. pt. 36 app. B § 104 (emphasis added). There is no special statutory exception for HIV in the ADA.[24]

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[23] *See also* Judith Rabkin, et al., *Stability of Mood Despite HIV Illness Progression in a Group of Homosexual Men*, Am. J. Psychiatry 154:2 at 231, 237 (1997) (compared to the "HIV-negative men, the HIV-positive men had slightly more anxiety and somatic depressive assessments," but "were not, by and large, clinically anxious or depressed"). *Amici* AIDS Action Council, et al., also considerably overstate CDC guidelines about things such as the danger of tap water. *Compare* AIDS Action Council, et al., Br. at 25 *with USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected With [HIV]: A Summary*, 44 MMWR, No. RR-8, 8-9 (July 14, 1995) *and Cryptosporidiosis: A Guide for Persons WithHIV/AIDS*, http://www.cdc.gov/ncidod/diseases/crypto/hivaids.htm (Feb. 11, 1998).

[24] By contrast, many States have laws that apply specifically to those with HIV. *See, e.g.*, Haw. Rev. Stat. § 515-6 (restrictive covenants void based on "race, . . . disability, age, or HIV"); Ill. Ann. Stat. ch. 20, § 301/30-5(aa) (Smith-Hurd) (discrimination prohibited based on "HIV status"); Ky. Rev. Stat. Ann. § 207.135(1) (Baldwin) (same); La. Rev. Stat. Ann. § 22:228 (West) ("terminal, incapacitating, or debilitating condition" includes "HIV"); Md. Code Ann., Health Occ., § 4-315(a) (dentists may not discriminate based on "HIV"); Mo. Ann. Stat. § 191.699 (Vernon) (health care professionals may not discriminate based on "HIV infection"); Mont. Code Ann. § 50-5-105 (same); N.J. Stat. Ann. § 10:5-5(q) (West) ("Handicapped shall also mean suffering from . . . HIV infection"); Vt. Stat. Ann. tit. 3, § 961 (unlawful to discriminate based on positive "HIV-related blood test"); W. Va. Code § 30-36-18 (1966) ("HIV" discrimination prohibited). Many of these laws directly regulate health care professionals. Because this field is traditionally occupied by the States, *see Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985); *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 772 (1976) (Burger, C.J., concurring), the Court should hesitate to interpret the ADA as a national health care regulatory act giving the force of law to implicit CDC guidelines.

Abbott also argues that everyone with a "serious, irreversible, life-threatening medical condition" (AMA Br. at 21) or a "contagious, incurable, fatal" condition (Resp't Br. at 28) is disabled. The theory is that the duration of life is substantially limited, and therefore all major life activities, whatever they are, are substantially limited. This view does not comport with the historical context, purposes, and language of the ADA, which are directed at persons with *past* or *present* functional limitations, not statistically probable future limitations, or even present conditions causing significantly shortened life-expectancies. *E.g.*, 29 C.F.R. pt. 1630 app. § 1630.2(h) ("impairment" under the ADA does *not* include "predisposition to illness or disease"). Many people by genetic predisposition or other condition (e.g., cancer, nicotine addiction, obesity) have significantly shortened life-expectancies. The ADA expands on the traditional idea of "handicap" by covering such individuals, but only if they have a record of a past or present functional limitation which is substantial, or are regarded as such.[25]

Congress could have passed the "Americans

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[25] This is one reason why statistics that 8% to 25% of the offspring of HIV-infected women have significantly shortened life expectancies do not make all fertile HIV-infected woman disabled, even if reproduction were a major life activity. Nor, contrary to the logic of Abbott's argument, would a nicotine addict's and/or functioning alcoholic's decision not to become pregnant make her disabled, even though "drug addiction and alcoholism" are impairments listed in 28 C.F.R. § 36.104.

with Terminal Illnesses Act," or the "Americans with HIV Act," but it did not. Even if every member of Congress wanted, expected, or assumed that HIV is always a disability, the objective import of the words in the statute does not support that interpretation. *See* Laurence Tribe, *Comment*, in *A Matter of Interpretation* 65, 65 (1997) ("[l]ike Justice Scalia, I never cease to be amazed by the arguments of judges, lawyers, or others who proceed as though legal texts were little more than interesting documentary evidence of what some lawgiver had in mind"); Ronald Dworkin, *Comment*, *id.* at 118; *see also Yellow Freight Systems v. Donnelly*, 494 U.S. 820, 826 (1990).[26]

Abbott also protests that it makes no sense to protect people with advanced "visible" HIV, but not asymptomatic HIV. The same can be said for almost every other condition: Why protect those who are substantially limited, but not those who are not quite as limited? It is simply inherent in the definition chosen by Congress.[27]

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[26] Dr. Bragdon is confident that an inquiry into why socially conservative opponents of the ADA maintained that all HIV carriers would be covered would disclose a purely political motive to exaggerate the ADA to make it look bad for their constituencies and to try to throw a late public relations obstacle in its path. *Cf. Gulf Offshore Co. v. Mobile Oil Corp.*, 453 U.S. 473, 483 (1981). Legislators on the other side hoped to accomplish their goal without having to amend the statute, since that could be difficult (i.e., if HIV, why not cerebral palsy, Huntington's disease, cancer, etc?). Thus, despite intense lobbying from AIDS organizations and a direct recommendation from the Presidential Commission on HIV to clearly include HIV as a disability, a majority in Congress (if it existed) lacked the courage of its convictions, settling for floor speeches and ambiguous committee reports. Now the same organizations lobby the Court with the same policy arguments. Regardless of their merit, they are properly directed at Congress and/or state legislatures, not the Court.

[27] Contrary to U.S. Br. at 19 n.11, Congress did not enact the ADA against a reasoned judicial consensus that HIV is always a disability. The cited cases are AIDS cases, e.g, *Cain v. Hyatt*; cases of substantial limitations of major life activities, *e.g.*, *Thomas v. Atascadero Unified Sch. Dist.*; and dicta citing an AIDS case, *Doe v. Garrett*. Moreover, the Court had expressly reserved the issue in *Arline*, which holds that persons with contagious diseases may be disabled, not that they are always disabled.

V. "MAJOR LIFE ACTIVITIES" HAS NO HELPFUL PLAIN OR ORDINARY MEANING.

Dr. Bragdon has been able to locate only two instances of the phrase "major life activity" or "major life activities" appearing outside a piece about the ADA definition of disability. Both were medical articles. Each equated "major life activity" with school, work, retirement, or keeping house.[28] Furthermore, ask a person unfamiliar with the ADA to list major life activities, and it is as likely he will answer "avoiding pain and seeking pleasure," "war and destruction," "the search for meaning," "gambling, drinking, and womanizing," or "culture and religion," as "seeing and breathing."[29] The "plain meaning" approach is therefore unhelpful or hopelessly over-inclusive.

"Major life activities" only makes sense as a term-of-art chosen to help circumscribe the meaning of "disability" for the purposes of the ADA. Reproduction, regardless of how vital it is to life, does not fit those purposes. That is why

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[28] Evans, et al., *The Quality of Life of Hemodialysis Recipients Treated With [rHuEPO]*, 263 JAMA 825, table 7 (1990); Lee Cohen, et al., *A Reevaluation of Risk of In Utero Exposure to Lithium*, 271 JAMA 146, 149 (1994) (indirectly citing Policy Research Inc., *Medical Practice Information Demonstration Project* at 4, 26 (Gov. Contract No. 282-77-0068 with HEW)).

[29] The same person is as likely to insist that reproduction is a major life event, not a major life activity.

reproduction is not found on HEW's or any other agency's list of major life activities. It is also why not a single comment of over 1,100 received during Justice Department rulemaking maintained that sexual activity and reproduction should be on the Justice Department's list of major life activities, was concerned they were not, or spoke on behalf of the problems of infertility or impotence.[30]

Furthermore, if reproduction (or whatever bundle of activities it refers to) is a "major life activity" because of its importance in life or to life, then nurturing others, feeding and clothing others, having relations with others (or whatever you want to call it) must in principle also be "major life activities" since they are just as vital to the life and growth of children (and the human race) as the bare acts of impregnation and giving birth. But given the extraordinarily broad definition of "impairment," if these forms of other-directed activities are also "major life activities," there *will* be the proverbial flood of litigation, and the ADA will expand into territories presently unimaginable. This is why "caring for others" has never been on any agency's list of major life activities.[31]

Also, contrary to Resp't Br. at 20 n.24 and U.S. Br. at 13, there is no one-to-one correspondence between the list of eleven "body systems" found in the regulatory definition of "impairment," 28 C.F.R. § 36.104, and "major life activities." Some body systems (e.g., skin, cardiovascular) have no corresponding major life

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30 ADA Comment Books #1 and #2 for Public Inspection (comments 100-1299). *See supra* note 12.

31 Construing "major life activities" to include *other-directed* activities is contrary to the impetus behind the ADA, which was to promote independent living. *See* National Council on the Handicapped, *On the Threshold of Independence* (1988) and *Toward Independence* (1986).

activity, and some major life activities (working, caring for one's self) have no corresponding body system. The inclusion of the reproductive system in the list of body systems means that if a woman, for example, is substantially limited in her ability to work because of incapacitating pain associated with dysmenorrhea or endometriosis, or has a record of substantial limitation due to ovarian cancer, she is not excluded from the definition of disability because the condition originates in her reproductive system.[32]

CONCLUSION

While Abbott makes many policy arguments, the better legal arguments support Dr. Bragdon's position. The judgment of the Court of Appeals should therefore be reversed.

Respectfully submitted,

JOHN W. McCARTHY
BRENT A. SINGER, Ph.D.
Counsel of Record
RUDMAN & WINCHELL, LLC
Attorneys for Petitioner
84 Harlow Street
Bangor, Maine 04401
(207) 947-4501

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32 Contrary to U.S. Br. at 10 n.3, no *Chevron* deference is appropriate because Congress did not delegate authority to an agency "to make specific policy determinations," *ABF Freight System v. NLRB*, 510 U.S. 317, 324 (1994); *see Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 696-697 (1991), concerning the meaning of "disability," and the Justice Department has no special expertise to apply, *see PBGC v. LTV Corp.*, 496 U.S. 633, 651-652 (1990).

KNOWLEDGE MAY BE HELD LIABLE FOR CIVIL RIGHTS VIOLATIONS WITHOUT A TRIAL.

A. Dr. Bragdon Made a Reasonable Judgment, Based on Then-Current Medical Knowledge, that Filling Ms. Abbott's Cavity in His Office Would Have Posed a Direct Threat to the Health or Safety of Others.

The following sampling of facts in the record illustrate that, for purposes of summary judgment review, Dr. Bragdon raised a genuine issue of fact under 28 C.F.R. § 36.208(c), as to whether he made an objectively reasonable judgment, based on then-current medical knowledge, that filling Ms. Abbott's cavity in his office on September 16, 1994, would have posed a direct threat to the health or safety of others.[12]

1. In 1991, the Occupational Safety and Health Administration (OSHA) promulgated its Final Standard for Occupational Exposure to Bloodborne Pathogens, 56 Fed. Reg. 64004 (Dec. 6, 1991). These standards apply to dentists. See American Dental Ass'n v. Martin, 984 F.2d 823 (7th Cir. 1993), cert. denied, 114 S. Ct. 172 (1993). OSHA concluded that dental workers who have occupational exposure to blood or certain body fluids are "at risk" of contracting HIV, and that the rate of HIV infection is low, but "not insignificant." 56 Fed. Reg. at 64032. (81a-82a) OSHA specifically rejected the American Dental Association's contention that OSHA overestimated the occupational risk for dentists. Id. at 64092. (83a-84a) OSHA explained that empirical findings are compatible with a finding of a one in 1,000 risk to dentists of a

12 For purposes of summary judgment review, "the evidence of the nonmovant [i.e., Dr. Bragdon] is to be believed, and all justifiable inferences are to be drawn in his favor." Anderson v. Liberty Lobby, Inc.,477 U.S. 242, 255 (1986). "Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, whether he is ruling on a motion for summary judgment or for directed verdict." Id.

fatal illness as a result of occupational exposure to HIV infected blood, and that such a risk has "clearly [been] defined . . . as a significant risk." Id. OSHA therefore requires, and the CDC recommends, the taking of certain "universal precautions" (gloves, masks, handwashing, etc.). They are called "universal" in the sense that they are to be used for all patients, not in the sense that they eliminate the risk to dentists of contracting HIV. In fact, when Senator Daniel Moynihan inquired of the CDC in 1995 as to the efficacy for dentists of taking "universal precautions," the Director of the CDC referred Senator Moynihan to "the two latest articles" on the subject. (85a-86a) The first article concerned only cutaneous exposures to blood, and reported an approximately 50% reduction by taking universal precautions. (225a) The second considered parenteral exposures as well, and concluded that "the implementation of UPs [i.e., universal precautions] should reduce the risk of occupational HIV infection by . . .62%." (89a)

This means that according to OSHA, evidence indicates that Dr. Bragdon and his assistants have a significant risk of contracting HIV without taking universal precautions. According to the latest studies recognized by the CDC, Dr. Bragdon and his assistants reduce that risk by 62% -- a little over half -- by taking universal precautions. Most reasonable minds would agree that a 62% reduction in a significant risk of contracting HIV still leaves a significant risk. Accordingly, Dr. Bragdon made a reasonable judgment, based on then-current medical knowledge, that the performance of an invasive procedure, such as filling Ms. Abbott's cavity near the gum line, would have posed a direct threat pursuant to 28 C.F.R. § 36.208(c).

2. In 1992, the Food and Drug Administration (FDA) issued recommendations for the prevention of HIV transmission. The FDA recommends a twelve month deferral

period for all potential blood donors "who have had contact with blood and body fluids through percutaneous inoculation (such as injury or accidental needlestick) or through contact with an open wound, non-intact skin, or mucous membrane during the preceding 12 months." (97a, 90a) This means that whenever a dentist has contact with any patient's blood by accidental needlestick or other sharps injury, the FDA, on account of concern for the transmission of HIV, recommends that the dentist not be permitted to donate blood for twelve months, to ensure that blood tests will detect HIV-antibodies if he is infected.**13** It is therefore reasonable to infer that the FDA, like OSHA, thinks there is a significant risk to dentists of contracting HIV when they are exposed to the blood of their patients.

Every time Dr. Bragdon fills a cavity such as Ms. Abbott's, there is a significant opportunity for him to be exposed to his patient's blood. See 56 Fed. Reg. at 64092 (82a) ("Dentists . . . are continually exposed to blood and bloody saliva during almost all dental procedures."). For example, during the injection of local anesthetic, accidental needlestick injuries to Dr. Bragdon occur before, between, and after injections, as a result of unexpected patient movements, such as biting down or flinching. (69a, ¶ 7; 77a-78a; 138a-139a; 176a) One of Ms. Abbott's experts testified that, for dentists, 1.5 accidental needlesticks per 100 injections, is a reasonable approximation. (154a-155a, ¶ 16) A startled patient can cause instruments, such as explorers (the "shepherd's crook" used to examine teeth), to be driven into the bone of the dentist's finger. (77a, ¶ 7; 139a) The CDC reports that during routine dental procedures, "contamination of saliva with blood is predictable [and] trauma to health-care workers' hands is common." MMWR, vol. 37, no. 24, p. 379

13 Blood tests used to determine if someone is HIV-positive actually detect the presence of HIV-antibodies, which typically do not develop until one to six months after infection.

(June 24, 1988). Dr. Bragdon testified that even doing his best to implement universal precautions, he sustains sharps injuries, most of which draw blood, at the rate of several times a week. (99a-100a) In one study, thirty-five percent of dentists reported between two and fifteen sharps injuries per month. (125a) When drilling a cavity near the gum line, it is not unusual for splatters of blood to reach the dentist. (70a, ¶ 9;102a) The drilling process itself creates an aerosol mist of tiny droplets of blood and bloody saliva that drifts up into the face of the dentist. (69a-70a) Consequently, when filling cavities, and performing other so-called "routine" procedures, it is not at all unusual for the blood and mucous membranes of dentists to be exposed to the blood of their patients. (70a, ¶ 12, 72a-74a)

A reasonable inference from the FDA recommendations concerning deferral periods following exposure to a patient's blood, and from the likelihood of Dr. Bragdon being exposed to the blood of a patient when filling a cavity near the gum line, is that there was a direct threat to Dr. Bragdon within the meaning of 28 C.F.R. § 36.208(c).

3. In June 1994, the CDC reported thirty-seven confirmed cases of occupational transmission of HIV to health care workers (including four to non-surgical physicians), and seventy-eight suspected occupational transmissions of HIV to health care workers, including seven suspected occupational transmissions of HIV to dental workers. (104a-107a) The seven suspected occupational transmissions of HIV to dental workers are cases in which it is reasonable to infer that transmission occurred, because the dental workers suffered occupational exposures to HIV-infected blood, and follow-up investigation by the CDC uncovered no non-occupational risk factors for the HIV-infected workers. (105a) In other words, the seven dental workers who were infected with HIV were "investigated and are without identifiable [non-occupational]

behavioral or transfusion risks." (110a n.3; 111a n.3) The CDC does not, however, refer to such cases as "confirmed," because unlike the thirty-seven confirmed cases of occupational transmission of HIV to health care workers, the infected dental workers did not have blood tests done at the time of exposure confirming that they were HIV-negative at that time. (Id.)**14**

Moreover, in the same June 1994 report, the CDC cautioned that its passive surveillance system for documenting occupational transmissions of HIV "most likely does not reflect the full extent of occupational transmissions," and that estimates are that "only 10% to 60% of percutaneous injuries are reported" (emphasis added). (105a) Based on this CDC report, it was reasonable for Dr. Bragdon to conclude that perhaps as many as seventy dental workers, and at least seven, had already suffered occupational transmissions of HIV, and therefore, there would have been a direct threat to him and his staff while performing invasive procedures on Ms. Abbott in his office.

4. In 1991, the CDC reported that a Florida dentist, despite using barrier precautions, transmitted HIV to five of his patients, between 1987 and 1989. (111a-1 - 130a) The routine procedures in question included restorative fillings, prophylaxes, and simple extractions. The CDC explained that

> [a]ll five patients received multiple injections

14 The Appeals Court dismissed the relevance of these seven infected dental workers by playing on the word "possible." Specifically, although the CDC refers to these suspected cases of HIV transmission as "possible" cases, it is obvious from the context of the CDC report that this does not mean "possible" in the sense that "anything is possible." In legal terminology, what the CDC calls "documented" cases, and what the Appeals Court and petitioner call "confirmed" cases, are on the order of "beyond a reasonable doubt," whereas "possible" cases are those in whichthe preponderance of the evidence suggests that occupational transmissions of HIV occurred.

> of local anesthetic, and a sharps injury during anesthetic administration could have resulted in contamination of the syringe apparatus with the dentist's blood. . . . A sharps injury could also result in direct contact of the dentist's blood with the patient's inflamed or nonintact oral tissues during the invasive procedures. Although the dentist began to routinely wear gloves in 1987, gloves do not prevent most injuries caused by sharp instruments.

(126a)

The CDC updated this study in 1993, and concluded that a sixth patient was also infected with HIV while receiving care from this dentist. Unlike the other patients, "this patient had neither dental extractions nor root canal therapy." (132a) Other than X-rays and a cleaning, there was only a single surface restorative filling (131a), just like the "routine procedure" at issue in this case.

In addition, experts agree that the risk of transmission of HIV from patient to dentist is greater than the risk of transmission of HIV from dentist to patient. For example, Dr. Molinari's article in the October 1993 issue of the Journal of the American Dental Association reports: "The risk of transmitting HIV from patient to HCW [health care worker] is much higher than the risk of transmitting from HCW to patient." (137a) Dr. Molinari later reiterated his view that "the danger is much greater for dentists and dental care workers than it is for patients" (emphasis added). (139a)

Given the documented transmissions of HIV from dentist to patients while filling a simple cavity and other "routine procedures," given that courts are in agreement that there is a direct threat to patients from HIV infected health

care workers, including dentists,15 and given experts' opinion that the risk to dentists is much greater than the risk to patients, it was again reasonable for Dr. Bragdon, or anyone else, to conclude that filling Ms. Abbott's cavity near the gum line would have posed a direct threat to him and his staff.

5. Dr. Bragdon also introduced as evidence an affidavit from Leon Kelleher, D.D.S. Dr. Kelleher directs a group of seventeen dentists who treat over 100 HIV-positive patients in the Chicago area. Dr. Kelleher testified that their "standard operating procedure is to avoid the use of aerosol producing instrumentation [i.e., the dentist's high speed drill] in known HIV+ cases." (140a, 143a) According to Dr. Kelleher, "[p]atients on whom the use of the high speed handpiece [i.e., the drill] is unavoidable are done with high volume evacuation under laminar flow conditions with hood or full face protection and remote air source for the operator." (143a) Dr. Kelleher's group adopted its protocols because of the results of a 1991 study conducted by Drs. Johnson and Robinson at Stanford University School of Medicine. (Id.) Drs. Johnson and Robinson reported that infectious HIV can be isolated from aerosols generated from HIV infected blood, and concluded that

> dentists . . . should avoid techniques which generate such aerosols . . . with patients known to be infected with HIV. Where such procedures are unavoidable, personnel should consider using high efficiency filtration masks and systems for containing aerosols.

(149a)

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15 E.g., Bradley v. Universtiy of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S. Ct. 1071 (1994); Mauro v. Borgess Medical Ctr., 886 F. Supp. 1349 (W.D. Mich. 1995); Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991).

Rather than filling Ms. Abbott's cavity in his one-dentist office in the outskirts of Bangor, where such high efficiency filtration devices are not available, Dr. Bragdon wanted to defer treatment to a local hospital setting, where he had reason to believe they were available. (101a) This was a reasonable judgment by a health care professional. Yet, without a trial, and despite conflicting expert affidavit's (150a-159a), two courts have now determined as a matter of law that Dr. Bragdon unlawfully discriminated against Ms. Abbott. Now pending in District Court is Ms. Abbott's application as a prevailing party for attorneys fees and litigation expenses in the amount of $205,190.63. The fact that Dr. Bragdon may owe over $200,000 for wanting to take the same precautions as are routinely taken by dentists in big cities, and that federal courts are in effect compelling him to take risks at work that other dentists routinely do not, is truly Orwellian, and deserving of this Court's attention.

6. In affirming the summary judgment against Dr. Bragdon, the Appeals Court held that all of the evidence presented by Dr. Bragdon, taken individually and cumulatively,16 did not raise a genuine issue for trial. The

16 Dr. Bragdon presented other compelling evidence as well. For example, he presented the direct affidavit testimony of Sanford F. Kuvin, M.S., M.D., D.T.M. & H. Dr. Kuvin, whose qualifications under Rule 702 as an expert witness on infectious diseases were not challenged , corroborated the sources of information already discussed, and concluded that there would have been a direct threat to Dr. Bragdon. (150a-160a) Dr. Kuvin also testified that according to CDC recommendations regarding the danger of tuberculosis ("TB"), dentists should decline to perform aerosol-generating procedures on an HIV-positive patient without high-efficiency particulate air filtration that was unavailable to Dr. Bragdon in his office. (152a-154a) Using a form of analysis recognized by the Fourth Circuit in Doe v. University of Md. Medical Sys. Corp., 50 F.3d 1261 (4th Cir. 1995), and empirical data available to Dr. Bragdon in 1994, Dr. Kuvin further testified that a conservative estimate of the risk that a dentist will receive at least one fatal, accidental needlestick, during 30 years of practice giving approximately one injection per working day to an HIV infected patient, is one in ten. (154a-156a) For

Appeals Court arrived at this result, ostensibly, by attaching a continuing presumption of correctness to the conclusions that it thought were implicit in the 1993 Guidelines. This is what the 1993 Guidelines actually say:

> This document updates previously published CDC recommendations for infection-control practices for dentistry (1-3) and offers guidance for reducing the risks of disease transmission among dental health-care workers (DHCWs) and their patients. . . .
>
> . . .
>
> A set of infection-control strategies common to all health care delivery settings should reduce the risk of transmission of infectious diseases caused by bloodborne pathogens such as HBV and HIV. . . .
>
> . . .
>
> For both HBV and HIV, the precise event or events resulting in transmission of infection in the dental setting have not been determined; . . .
>
> . . .
>
> Additional information is needed for accurate assessment of factors that may increase the risk for transmission of bloodborne pathogens and other infectious agents in a dental setting.

(182a, 183a, 184a, 199a)

The Court will search in vain in the 1993 Guidelines (181a-199a) for any more definitive statement of the significance of the risk to dentists, or of the rationality or

the sake of comparison, the risk of sustaining a fatal, accidental needlestick, while giving just one injection to an HIV infected patient, is slightly greater than the risk of having a fatal parachute accident while skydiving. (161a-162a, 164a, 165a-166a)

legality of taking additional precautions while working on persons known to be HIV positive. In fact, although the plaintiffs vaunt the significance of the 1993 Guidelines, they did not cite in their appellate briefs a single word from that document. Nor, apart from two references in the United States' brief to a 1993 CDC article about the risk of occupational infection in operating and delivery room settings (also cited by Dr. Bragdon in his brief), did the United States, Ms. Abbott, or any of their health department amici, cite a single word from any published CDC source, or even a single word from any of their own published sources.

The outcome of this case was therefore determined by the application of an extraordinarily unusual standard of review at summary judgment, and not by the failure of Dr. Bragdon to present evidence, including direct expert witness testimony,**17** that would have otherwise entitled him to a trial under normal summary judgment principles. Cf. Doe v. Johnston, 476 N.W.2d 28, 31 (Iowa 1991) (materiality of risk was properly a jury question when conflicting expert testimony put risk of contracting HIV between 1/100,000 and 1/1,000,000); cf. also Carter v. Temple-Inland Forest Products Corp., 943 S.W.2d 221 (Tex. App. 1997) (reasonableness of party's fear of developing cancer was properly a jury question when the evidence was that the risk of developing cancer was between 1/100 to 1/500,000).**18**

B. Ironically, Dr. Bragdon, More Than Ms. Abbott,

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17 See note 16 supra.

18 Another clear indication that Dr. Bragdon would have survived summary judgment on normal summary judgment principles, is that while the Appeals Court did its best to discount, ignore, and belittle the evidence presented by Dr. Bragdon, it did not indicate that the outcome would have been the same under a standard of review more favorable to him. In light of how narrowly the Appeals Court attempted to write on the issue of direct threat, the Appeals Court surely would have added such a proviso if it thought it were true.

Must Confront Myth and Prejudice in this Case.

It is sometimes assumed that among the poorly educated, there is an irrational fear and prejudice that HIV is easily transmitted. Whether or not this is true, there is most certainly a myth and prejudice among the well educated, including those like ourselves who have had friends or relatives become infected with HIV or die of AIDS. The myth is that apart from activities like unprotected sex and sharing dirty needles, science has shown that the risk of transmission of HIV to be nil, even for dentists working with sharp instruments in bloody mouths. The prejudice is that dentists or doctors who think otherwise, or who want to take significant additional precautions when working with even small amounts of HIV infected blood, must be ignorant, homophobic, stigmatizing, cowardly. unethical, and/or uncaring.

This myth and this prejudice is perfectly exemplified by a recent cover story on this case in the American Bar Association Journal, in which the author assumes and/or implies for his audience that there is clear scientific evidence of no significant risk to dentists. He writes:

> Although the evidence is to the contrary, dentists may perceive greater risks of contracting HIV by coming into contact with a patient's blood. A typical dental examination is a more invasive procedure than a routine physical exam and often draws blood, even during routine cleaning.

(207a - emphasis added) The author, of course, does not explain what is the "evidence to the contrary," or in what medical journal or CDC publication it can be found.

The vital point for the Court to understand is that no-where in the record has the CDC, any of Ms. Abbott's four experts, or any of the many amici public health organizations, been able to point to a single, scientific, reasoned analysis that was available to Dr. Bragdon, concluding that the risk to a dentist filling a cavity (or performing other procedures which routinely draw patients' blood) is insignificant, or that because of a crisis in the availability or cost of dental care for HIV-infected individuals, dentists must be compelled by federal law to perform invasive procedures in their offices on patients known to be infected with HIV, without taking significant precautions beyond those recommended by the CDC for all patients. There is no such analysis. It is a myth that there is, and this myth serves a political agenda, just as much as the myth that AIDS is a gay disease serves a differing political agenda.[19]

Ms. Abbott herself plays upon this myth by repeatedly making the fallacious argument that the risk to dentists is nil because, except for the seven suspected transmissions of HIV to dental workers documented by the CDC, and the six transmissions to dental patients also documented by the CDC, the CDC has never documented another case of HIV transmission in the estimated over "one billion dental procedures" performed by "250,000 other dentists" in this country in "the last fourteen years." (Appellee's Br. at 8)

But what kind of argument is this, when people can be

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19 The morally righteous tone to the plaintiffs' political agenda is illustrated by the response of one of Ms. Abbott's experts to the question of whether Dr. Bragdon should be legally compelled to treat HIV-infected patients, assuming there is a substantial likelihood of a transmission of HIV to him or his staff once every 10 years, or even once every year. His answer was "Yes," "Life is a risk," "[T]here's obviously a risk, and I think he should provide services. I'm not saying when you provide services you provide it risk free and nothing happens. So the time frame makes no difference to me." (170a-171a)

HIV-positive for many years without knowing it, and the CDC admits that its passive surveillance system for documenting HIV transmissions to dentists underreports by as much as 90%? (105a)

Scientifically, the argument is specious, but rhetorically, it helps reinforce the myth that it is nigh unto impossible to transmit HIV, outside of unprotected sex and dirty needles. The truth is, however, a little drop of blood on an open wound or mucous membrane can transmit HIV, although in light of the cruelty of many in society to those with HIV, we prefer to ignore it.**20** But this does not mean that the government ought to be in the business of compelling private health care providers to act against their reasonable judgments, even if reasonable health care providers disagree about the significance of a risk.

C. The Appeals Court's Decision Sets a Very Bad Precedent that Will Have Deleterious Effects On Efforts to Build an Improved, Coherent Administrative System for the Regulation of Small But Significant Health Risks.

An expert in administrative law recently observed that "serious problems currently plague efforts to regulate small, but significant, risks to our health." Stephen Breyer, Breaking the Vicious Circle, 10 (Harvard Univ. Press 1993). The Appeals Court's opinion, if left to stand as law, will exacerbate those problems.

More precisely, this case is being watched carefully by state and national public health agencies and health care providers (180a), including, of course, the many national and state agencies and associations that filed amicus briefs in the

20 The CDC reports that "visible blood on device" is a significant factor for increasing the risk of HIV infection for a health-care worker following a percutaneous injury. MMWR, vol. 44, no. 50, p. 929-932 (Dec. 22, 1995).

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v.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

SETH P. WAXMAN
Solicitor General
BILL LANN LEE
Acting Assistant Attorney General
LAWRENCE G. WALLACE
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General
JESSICA DUNSAY SILVER
THOMAS E. CHANDLER
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

45 pp

QUESTIONS PRESENTED

1. Whether reproduction is a "major life activit[y]" under the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 *et seq.*

2. Whether asymptomatic individuals infected with HIV are *per se* disabled within the meaning of the ADA.

3. Whether courts must defer to a dentist's professional judgment in determining whether performing a routine dental procedure on a patient infected with HIV poses a direct threat to the health or safety of that dentist or others, under 42 U.S.C. 12182(b)(3).

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INTEREST OF THE UNITED STATES

This case raises important questions regarding the application of the Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.* (ADA), to individuals infected with the Human Immunodeficiency Virus (HIV). The Attorney General has statutory authority to enforce the ADA's public accommodations provisions, see 42 U.S.C. 12188(b), pursuant to which the United States has brought two lawsuits seeking to apply the ADA in circumstances virtually identical to those present here.[1] The Department of Justice has also issued extensive regulations and interpretive guidance concerning two of the key provisions at issue in this case: the definition of the term "disability" and the proper application of the "direct threat" exception under

[1] See *United States* v. *Castle*, No. H-93-3140 (S.D. Tex.) (consent decree dated Sept. 22, 1994); *United States* v. *Morvant*, 898 F. Supp. 1157 (E.D. La. 1995) (summary judgment for the United States).

the ADA. See 42 U.S.C. 12186(b); 28 C.F.R. 36.104, 36.208; 28 C.F.R. Pt. 36 App. B.

The United States has additional interests in this case. The Centers for Disease Control and Prevention (CDC) have issued recommended infection control practices for dentistry, which have been largely incorporated in an Occupational Safety and Health Administration rule regarding exposure to bloodborne pathogens. See generally *American Dental Ass'n* v. *Martin*, 984 F.2d 823 (7th Cir.), cert. denied, 510 U.S. 859 (1993). Moreover, the then-Director of the CDC's Division on Oral Health testified in this case to the CDC's position that persons infected with HIV may be safely treated in a private dental office if universal precautions are employed. The United States has a substantial interest in the deference to be accorded to those judgments. For all these reasons, the United States participated in this case as amicus curiae in both the district court and the court of appeals.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of the Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.*, and of the regulations promulgated by the Attorney General pursuant to the Act are reproduced at Appendix, *infra*, 1a-8a.

STATEMENT

Petitioner is a dentist with a practice in Bangor, Maine. This case arises from his refusal to provide routine dental treatment to respondent Sidney Abbott, solely because Ms. Abbott is infected with the Human Immunodeficiency Virus (HIV).

1. HIV is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). Pet. App. 31a. "People exposed to HIV may contract the virus, and if so, will develop HIV antibodies and become HIV positive." *Ibid.* HIV disease compromises the body's immune system and normally leads to opportunistic infections, malignancies, and ultimately death. But these symptoms do not appear all at once. In fact, "[i]ndividuals may carry HIV for several years without manifesting the collection of symptoms known as AIDS." *Ibid.* Persons with such "asymptomatic" HIV remain infectious, however. And, even during the "asymptomatic" period, the HIV virus continues to multiply and "create[] abnormalities in [their] blood and lymphatic systems. " *Id.* at 32a. HIV may be transmitted by intimate sexual contact with an infected person, by invasive exposure to infected blood, or from mother to child during pregnancy, birth, or breast feeding. J.A. 87, 103. Persons cannot contract HIV through casual contact with an infected individual. J.A. 103.

Both the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) have addressed the question of how HIV-infected patients may be safely treated in dental offices. The CDC issued Recommended Infection-Control Practices for Dentistry in 1986 and revised recommendations in 1993. Pet. App. 181a-199a. It also issued Recommendations for the Prevention of HIV Transmission in Health Care Settings, including dentistry, in 1987. R. 53, Exh. 17. And OSHA issued a final rule on Occupational Exposure to Bloodborne Pathogens in 1991. 29 C.F.R. 1910.1030. Because health care workers cannot know with certainty whether they are treating an infectious patient, those guidelines dictate the use of "universal precautions"—infection control procedures under which every patient is treated as if the patient carries an infectious bloodborne pathogen (such as HIV or Hepatitis B). Pet. App. 183a; J.A. 88, 103-104. The procedures include protective attire and barrier techniques such as gloves, gowns, protective eyewear, surgical masks and/or face shields; proper sterilization of all dental instruments, including heat sterili-

zation of dental handpieces after each use; and proper disinfection of the dental unit and operatory surfaces. Pet. App. 185a-199a; J.A. 88-89, 103-105.

2. Respondent Abbott tested positive for HIV antibodies in 1986; she was, however, "asymptomatic" at that time and remained so at least until the time of the district court's judgment in 1995. Pet. App. 31a-32a. In September 1994, she arrived at petitioner's dental office for a prescheduled appointment. *Id.* at 3a. At the office, respondent was asked to fill out a medical questionnaire. She disclosed on that form that she had tested positive for HIV. *Ibid.*; see J.A. 48-51. After petitioner examined respondent and concluded that she had a cavity, he informed her that "pursuant to his infectious disease policy, he would not fill her cavity in his office." Pet. App. 3a. He stated that his policy was to treat people with infectious diseases in a hospital setting, although at that time he in fact did not have admitting privileges at any hospital and had never inquired about obtaining such privileges at any hospital. J.A. 31. Petitioner offered to treat respondent at a hospital at his regular fee, but informed her that she would have to pay "whatever the hospital charged for the use of its facilities." Pet. App. 3a. Respondent refused the offer. *Ibid.*

3. Respondent then filed this action, alleging that petitioner had violated Title III of the Americans with Disabilities Act, 42 U.S.C. 12181 *et seq.* (ADA), which prohibits public accommodations from discriminating on the basis of disability. See 42 U.S.C. 12182. The parties filed cross-motions for summary judgment on the issues of liability and the ADA's constitutionality. The district court granted respondent's motion for summary judgment and denied petitioner's. Pet. App. 31a-65a.[2]

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[2] The United States intervened in the district court to defend the constitutionality of the ADA and also participated as amicus curiae regarding other issues in the case. The district court ultimately granted summary judgment to Abbott with regard to petitioner's constitutional challenges to the application of the ADA, see Pet. App. 54a-62a, and petitioner did not renew those claims on appeal. The United States continued to participate as amicus curiae in the court of appeals with regard to the remaining, nonconstitutional issues in the case.

After Abbott amended her complaint to include a claim under the Maine Human Rights Act, the Maine Human Rights Commission intervened as a plaintiff. R. 14, 23. The district court found that petitioner's conduct violated the Maine Human Rights Act for the same reasons that it violated the ADA. Pet. App. 52a-54a.

Under the ADA, "[t]he term 'disability' means, with respect to an individual * * * a physical or mental impairment that substantially limits one or more of the major life activities of such individual." 42 U.S.C. 12102(2). The court held that respondent was disabled under that definition. Relying in part on regulations promulgated by the Department of Justice, see 28 C.F.R. 36.104, the district court concluded "that asymptomatic HIV constitutes a physical impairment for the purposes of the ADA." Pet. App. 35a. The court also concluded that "[r]eproduction, one of the most fundamental of human activities, must constitute a major life activity." *Id.* at 37a. And the court found that respondent's HIV infection "substantially limits" that major life activity. *Id.* at 40a. That is because "an HIV positive mother runs the risk of infecting her child, during pregnancy, through childbirth or, if she chooses to do so, through breast feeding," and because respondent's HIV infection, by severely limiting her life expectancy, would likely limit her ability to engage in "the process of caring for and raising a child." *Ibid.* The court also noted respondent's "fear of harm to her immune system." *Ibid.*

Petitioner claimed that, even if respondent was disabled, he need not provide her with the needed dental treatment because such treatment would have posed a "direct threat"

to himself or others under 42 U.S.C. 12182(b)(3), which provides that one who furnishes services need not "permit an individual to participate in or benefit from [the provider's] services * * * where such individual poses a direct threat to the health or safety of others." 42 U.S.C. 12182(b)(3). The term "direct threat" is defined in the ADA as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." *Ibid.* The district court held that "treatment of [respondent] in [petitioner's] office poses no direct threat to the health or safety of others." Pet. App. 51a-52a. Characterizing petitioner's evidence on this point as "conjecture", the court based its decision on "the current state of medical knowledge, * * * defer[ring] to the reasonable medical judgments of public health officials." *Id.* at 45a.

4. The court of appeals affirmed. Pet. App. 1a-30a. The court held "unhesitatingly that HIV-positive status, simpliciter, whether symptomatic or asymptomatic, comprises a physical impairment under the ADA." *Id.* at 6a. The court also held that reproduction is a "major life activity." The court explained that the "plain meaning of the word 'major' denotes comparative importance," and that "reproduction, which is both the source of all life and one of life's most important activities, easily qualifies under that criterion" as a major life activity. *Id.* at 8a. The court rejected petitioner's arguments that "an activity must be performed either frequently or universally before it can be classified as a major life activity." *Id.* at 10a. The court also noted that even if it assumed, favorably to petitioner, that respondent had to show that reproduction is a major life activity for her, see *id.* at 12a, "a fact finder could reach no conclusion other than that reproduction, if a major life activity at all, constitutes such for [respondent]," *id.* at 13a.

The court agreed with the district court that respondent's HIV infection "substantially limits" the major life activity of reproduction. The court noted that petitioner conceded "that an HIV-positive pregnant woman faces an approximately 25% risk of transmitting the virus to her child without AZT therapy and an 8% risk of viral transmission with such therapy." Pet. App. 14a. The court ruled that "[n]o reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity." *Ibid.* The court further noted that "even if [respondent] gives birth to a healthy child, she probably will not live long enough to complete the task of raising the child to adulthood." *Id.* at 15a. The court therefore held that "HIV-positive status is a physical impairment that substantially limits a fecund woman's major life activity of reproduction," and that respondent is therefore "disabled" under the ADA. *Ibid.*

Finally, the court rejected petitioner's argument that providing routine dental treatment to respondent would pose a "direct threat" to himself or others. Relying in part on Department of Justice regulations, see 28 C.F.R. 36.208(c), the court noted that the presence or absence of a direct threat must be determined with respect to "an objective standard featuring the best evidence available at the time [the provider] refuse[s] to render treatment to disabled persons." Pet. App. 18a. The court held that the ADA requires "giv[ing] prima facie force to the views of public health authorities," while "permit[ting] a service provider to challenge those views based on contrary, properly supported opinions voiced by other recognized experts in the field." *Id.* at 21a. The court found that respondent had produced "competent evidence of reasonable medical judgments by public health officials, not contradicted by other public health authorities" that providing routine dental care to her "in an office environment does not pose a

direct threat to the dentist's health." *Id.* at 24a. The court ruled that each item of petitioner's evidence to the contrary "is too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact." *Id.* at 29a. In addition, the court concluded that, even taken together, petitioner's evidentiary proffers "are likewise insufficient * * * to call into legitimate question the lower court's entry of summary judgment." *Ibid.*

5. On November 26, 1997, this Court granted review limited to the first three questions presented in the petition for certiorari.

SUMMARY OF ARGUMENT

Respondent, who is infected with the HIV virus, has a "disability" covered by the ADA. There can be little dispute with the clear medical evidence that infection with the HIV virus constitutes an "impairment," from the time the virus enters the body and begins to attack the blood and lymphatic systems. Thus, HIV infection is a disability if that impairment "substantially limits" respondent in the conduct of a "major life activity." The court of appeals correctly held that it does.

Reproduction is a "major life activity." Congress's use of the term "major" requires an assessment of the relative significance or importance of an activity in human life. As the court of appeals held, the complex of activities constituting reproduction—including conception, birth, and child-rearing—is one of the most significant activities in which human beings engage. This Court has recognized that choices about whether to bear or beget children are "central to personal dignity and autonomy." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992). While reproduction is not universal and is not engaged in with the same frequency as walking or breathing, it is the source of all human life and is indispensable to its perpetuation. For

all these reasons, it is a "major life activity" for human beings.

The ADA requires only that an impairment "substantially limit"—not entirely eliminate all possibility of engaging in—a major life activity. The court of appeals therefore correctly held that respondent's HIV infection substantially limits the major life activity of reproduction. The infection limits the conditions and manner under which she can become pregnant, because it makes unprotected intimate sexual relations life-threatening for her partner. The infection also would threaten the life of a child, since it can be passed from mother to child before or during birth or during breastfeeding. Finally, the infection limits reproduction—and other major life activities as well—by drastically shortening respondent's life expectancy and thereby limiting the likely duration of her ability to engage in childrearing.

The holding that HIV-positive individuals are covered under the ADA is compelled not only by the statutory text, but also by the statute's legislative history and administrative interpretations. The definition of "disability" is derived virtually verbatim from the Rehabilitation Act. That Act had been construed by both courts and the Department of Justice to cover asymptomatic HIV-positive individuals. When Congress chose to adopt the Rehabilitation Act coverage formula in the ADA, it was well aware of the results that had been reached under the Rehabilitation Act, and the committee reports expressly endorsed those results and approved similar coverage for HIV-positive individuals under the ADA.

The court of appeals also correctly held that an asymptomatic HIV-positive patient does not pose a direct threat to dental health care workers performing routine dental work. The Centers for Disease Control and numerous other professional organizations have concluded that, because a dental worker can never be certain whether a

given patient is a carrier of bloodborne or infectious diseases, universal precautions protecting against infection should be followed during all dental work. Those same organizations have concluded that, if such precautions are followed, it is safe to perform routine dental procedures on HIV-positive individuals. Such reasonable medical judgments, reached by those entrusted with the public health, are entitled to substantial deference. To rebut those judgments, petitioner was able to offer only unsupported conjectures and hypotheses. Accordingly, the court of appeals correctly held that performing routine dental work on respondent would not have posed a direct threat to petitioner or others.

ARGUMENT

I. ASYMPTOMATIC HIV INFECTION IS A "DISABILITY" UNDER THE AMERICANS WITH DISABILITIES ACT

An individual has a "disability" for purposes of the Americans With Disabilities Act if she has "a physical or mental impairment that substantially limits one or more of [her] major life activities." 42 U.S.C. 12102(2)(A). HIV infection clearly constitutes a physical "impairment," for it is a "physiological disorder or condition" that affects, among others, the "hemic and lymphatic" system. 28 C.F.R. 36.104 (definition of "disability," subpart (1)(i)).[3]

[3] Under 42 U.S.C. 12186(b), Congress required that "the Attorney General * * * issue regulations * * * to carry out the provisions of [Title III of the ADA]." Although the definition of "disability" is not in Title III, the definition does expressly apply to "this chapter," which includes Title III, and the definition is essential in construing and administering Title III. See, *e.g.*, 42 U.S.C. 12182(a) ("No individual shall be discriminated against on the basis of *disability* in [public accommodations].") (emphasis added). Accordingly, the Department of Justice regulations are entitled to deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984).

Department of Justice regulations implementing Title III of the ADA specifically list "HIV disease (whether symptomatic or asymptomatic)" as an example of an "impairment." *Ibid.* (definition of "disability," subpart (1)(iii)). See App., *infra*, 3a. The court of appeals noted that petitioner "does not seriously advocate an antithetical view," and held "unhesitatingly" that the status of being HIV-positive, "whether symptomatic or asymptomatic, comprises a physical impairment under the ADA." Pet. App. 6a (also citing cases). See also J.A. 55 (affidavit describing "abnormalities" present in asymptomatic HIV infected person).

The Department of Justice has also long taken the position that asymptomatic HIV infection is a disability under the ADA, either because it "substantially limits a major life activit[y]" of infected individuals or because the reactions of others to infected individuals cause such individuals to be treated as though they are disabled under the "regarded as" prong of the ADA's definition of "disability," 42 U.S.C. 12102(2)(C). See pp. 19-21 & n.12 *infra*; see also nn. 7, 16, *infra*. In this case, however, the courts below did not reach any question concerning major life activities other than reproduction that are limited by the HIV infection, and they did not address the "regarded as" test for disability. Both courts instead merely held that respondent's asymptomatic HIV infection substantially limits respondent's major life activity of reproduction. For the reasons given below, that conclusion should be affirmed.

A. Reproduction Is A "Major Life Activity" Under The ADA

1. a. The court of appeals correctly held that reproduction is a "major life activit[y]" under the ADA. Dictionary definitions, thoroughly canvassed by the court of appeals, uniformly make clear that "[t]he plain meaning of the

word 'major' denotes comparative importance" and that "the touchstone for determining an activity's inclusion under the statutory rubric ['major life activities'] is its significance." Pet. App. 8a. As the court noted, "reproduction, which is both the source of all life and one of life's most important activities, easily qualifies under that criterion." *Ibid.* Indeed, petitioner concedes (Br. 34) that "[o]bviously activities such as having sex, giving birth, changing diapers, and loving and educating one's children are activities of paramount importance to many Americans and in that sense are major life activities."

This Court's decisions have made clear the significance of reproduction in human life. Reproduction involves not only the act of conception, but also the physical processes facilitating conception, the ability to engage in sexual activity leading to conception without endangering oneself or one's partner, and the child-rearing and nurturing relationship following conception. "Our society has long recognized the fundamental importance of each element of this cluster of activities." Pet. App. 7a. The "decision whether to bear or beget a child," *Eisenstadt* v. *Baird*, 405 U.S. 438, 453 (1972), involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992). Indeed, reproduction has been recognized as "one of the basic civil rights of man." *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942). The interests in raising one's children are similarly deep-rooted, see *Stanley* v. *Illinois*, 405 U.S. 645, 651 (1972), and decisions relating to procreation, reproduction, and childrearing are constitutionally protected. *Planned Parenthood*, 505 U.S. at 851.

The applicable regulations also support the conclusion that reproduction is a major life activity. Under Section 36.104, "[t]he phrase *major life activities* means functions such as caring for one's self, performing manual tasks,

walking, seeing, hearing, speaking, breathing, learning, and working."[4] As the wording of the regulation makes clear, that list is not exhaustive, but rather was intended to elucidate just how important an activity must be in order to be regarded as "major." Reproduction is clearly as important as many of the activities on that list, and therefore "fits comfortably within" the sweep of the regulation. Pet. App. 9a. Indeed, the same regulation defines "physical * * * impairment" to include "[a]ny physiological disorder or condition * * * affecting [the] reproductive [system]." 28 C.F.R. 36.104. To inquire whether a physiological disorder impairs the reproductive system is logically equivalent to asking whether it affects reproduction. Hence, if even a substantial limitation on reproduction were not covered under the ADA because reproduction is not a major life activity, then including reproductive disorders as "impairments" under the ADA would be entirely inefficacious; such impairments could never be relevant to a finding of disability under the ADA. Therefore, the regulation plainly contemplates that reproduction is a major life activity. See Pet. App. 9a; *Pacourek* v. *Inland Steel Co.*, 916 F. Supp. 797, 801-802 (N.D. Ill. 1996).

b. Petitioner argues (Br. 14) that "the focus of the ADA is on public, not private family life," and (Br. 29) that Congress in enacting the ADA was not "contemplating the obstacles faced by persons suffering from reproductive disorders, such as impotence and infertility." Congress, however, chose to use the term "major life activities" in the ADA, not some other term—such as "economically significant activities" or "activities in public life"—that would have been more susceptible to the construction petitioner urges. And, of course, the focus of the Act's protec-

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[4] This list is drawn from the regulations issued under the Rehabilitation Act of 1973. See 45 C.F.R. 84.3(j)(2)(ii) (defining major life activities).

tions remains on discrimination encountered in public life, rather than in private family life. For some categories of reproductive disorders, there may be little basis for concern that individuals with those disorders will suffer discrimination. In cases in which individuals with such disorders do suffer discrimination—as, for example, when the disorders are caused by an infectious agent and others react irrationally to fear of contagion—protection under the ADA fits well within the letter and purposes of the statute.

This Court in *School Board of Nassau County* v. *Arline*, 480 U.S. 273 (1987), rejected an argument analogous to that which petitioner advances here. *Arline* was decided under the Rehabilitation Act, which defined covered ("handicapped") individuals in terms virtually identical to the definition of covered individuals (using the term "disability" instead) in the ADA. See 480 U.S. at 279. The plaintiff in that case was covered because she suffered from tuberculosis, a disease that in acute form substantially limited her respiratory system, *i.e.*, the "major life activity" of breathing. See *id.* at 281. Just as in this case, however, the plaintiff did not suffer discrimination because that major life activity was impaired. Instead, again as in this case, the plaintiff suffered discrimination because the defendant feared (irrationally) that the plaintiff's impairment would be contagious.[5] This Court held that such discrimination was within the ambit of the Rehabilitation Act: "Allowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504, which is to ensure that handicapped individuals are not denied jobs or other bene-

[5] See 480 U.S. at 281 n.6 (noting defendant's argument that adverse action was taken against plaintiff "not because of her diminished physical capabilities, but because of the threat that her relapses of tuberculosis posed to the health of others").

fits because of the prejudiced attitudes or the ignorance of others." 480 U.S. at 284. The same conclusion follows here.

c. Petitioner also contends (Br. 36) "that reproductive activities, for human beings, are largely moral and lifestyle choices, in contrast to walking, seeing, hearing, speaking, and breathing." For similar reasons, two district courts have held that reproduction is not a major life activity because it is not undertaken with the frequency of activities such as eating, walking, and breathing, and because not all people choose to do it. See *Krauel* v. *Iowa Methodist Medical Ctr.*, 915 F. Supp. 102, 106 (S.D. Iowa 1995), aff'd, 95 F.3d 674 (8th Cir. 1996); *Zatarain* v. *WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), aff'd mem., 79 F.3d 1143 (5th Cir. 1996).[6]

[6] The vast majority of courts that have reached the issue have concluded that reproduction is a major life activity. See, *e.g.*, *Berk* v. *Bates Advertising USA, Inc.*, 1997 WL 749386, at *5 n.3 (S.D.N.Y. Dec. 3, 1997); *Hernandez* v. *Prudential Ins. Co.*, 977 F. Supp. 1160, 1164 (M.D. Fla. 1997); *Bielicki* v. *City of Chicago*, 1997 WL 260595, at *3 (N.D. Ill. May 8, 1997); *Soodman* v. *Wildman, Harrold, Allen & Dixon*, 1997 WL 106257, at *5 (N.D. Ill. Feb. 10, 1997); *Pacourek* v. *Inland Steel Co.*, 916 F. Supp. 797, 801-804 (N.D. Ill. 1996); *Erickson* v. *Board of Governors*, 911 F. Supp. 316, 320-323 (N.D. Ill. 1995); *Doe* v. *Kohn, Nast & Graf, P.C.*, 862 F. Supp. 1310, 1318-1321 (E.D. Pa. 1994); see also *McWright* v. *Alexander*, 982 F.2d 222, 226-227 (7th Cir. 1992) (under Rehabilitation Act); *Rivera* v. *Heyman*, 1997 WL 620837 (S.D.N.Y. Oct. 7, 1997) (under Rehabilitation Act); *Doe* v. *District of Columbia*, 796 F. Supp. 559, 568 (D.D.C. 1992) (under Rehabilitation Act); *Thomas* v. *Atascadero Unified School Dist.*, 662 F. Supp. 376, 379 (C.D. Cal. 1987) (under Rehabilitation Act); *Cain* v. *Hyatt*, 734 F. Supp. 671, 679 (E.D. Pa. 1990) (construing same language under Pennsylvania Human Relations Act). Aside from *Krauel* and *Zatarain*, the only other court that has concluded that reproduction is not a major life activity is *Cortes* v. *McDonald's Corp.*, 955 F. Supp. 541, 545-546 (E.D.N.C. 1996). In *Runnebaum* v. *Nationsbank of Maryland*, 123 F.3d 156 (1997) (en banc), the Fourth Circuit recently addressed this issue, but no opinion was joined

Petitioner's contention is mistaken. Initially, insofar as reproduction includes raising one's children, it is an activity that may and often does occupy a large portion of a parent's waking life, particularly while the children are young. In any event, nothing in the statute suggests that an activity need be undertaken with any particular degree of frequency or universality in order to be considered "major." As the court of appeals noted (Pet. App. 8a), standard definitions of the term "major" refer to significance or importance, not frequency or universality. The perpetuation of human life qualifies. Moreover, the regulations list activities such as "working" or "learning" that would presumably be viewed as "moral and lifestyle" choices under petitioner's cramped definition. For example, many people—including the retired, those who choose to be full-time parents, and those who simply choose not to work—do not have employment. Nonetheless, even petitioner does not suggest that "working" is not a "major life activity."

B. HIV Infection "Substantially Limits" Respondent's Major Life Activity Of Reproduction

The court of appeals also correctly held that, at least for fertile women of childbearing age, HIV infection "substantially limits" engaging in the "major life activit[y]" of reproduction.[7] A person is "substantially limit[ed]" in an

by a majority of the judges. See *id.* at 170-171 (opinion of Williams, J.); *id.* at 183-185 (opinion of Michael, J., dissenting).

[7] In reviewing the judgments in this case, the Court need not address the effects of HIV infection on other major life activities. We note, however, that because HIV infection is an incurable and invariably fatal disease, it can be expected to substantially limit not only reproduction, but also many of the infected individual's other major life activities. HIV commences a process culminating in debilitating opportunistic infections and premature death. J.A. 55, 87. It limits all major activities by materially restricting the "duration under which" they can be performed. 28 C.F.R. Pt. 36 App. B, § 36.104, at 611. Even

activity if, "in comparison to most people," she is "restricted as to the conditions, manner, or duration under which" she can perform it. 28 C.F.R. Pt. 36 App. B, § 36.104, at 610-611. HIV infection limits the activity of reproduction because the HIV infection substantially limits the physical process of producing a healthy baby, and because it more generally limits a parent's ability to care for and raise the child by drastically limiting the length of time during which she can do so.[8]

1. Initially, a fertile woman's HIV infection limits her ability to become pregnant. As is by now well known, "[s]exual contact with exchange of body fluids constitutes the major risk factor for transmitting or contracting HIV infection." J.A. 87. The risk of such exchange can be greatly reduced by use of a condom.[9] Because the condom

long before it results in death, it limits marital choices, career choices (particularly those that require extensive training), and educational/learning options (by making long courses of study impractical). See also *State* v. *Clausen*, 491 N.W.2d 662, 666 (Minn. Ct. App. 1992) (difficulty of obtaining insurance); *Anderson* v. *Gus Mayer Boston Store*, 924 F. Supp. 763, 777 n.37 (E.D. Tex. 1996) (noting difficulty of travel because HIV-positive individuals "must be always mindful of exposure to bacterial infection and fungi or even places requiring vaccinations").

[8] Petitioner argues (Br. 16-27) that HIV infection is not a "per se" disability under the ADA. Compare *Ennis* v. *National Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 60 (4th Cir. 1995) (ADA requires individualized proof that HIV-positive status substantially limits a major life activity). We agree that the statute requires the impairment to substantially limit the particular plaintiff, as the record establishes in this case. See Pet. App. 13a. At the same time, however, some impairments substantially limit the major life activities of large classes of persons—or even of all persons suffering from them. In our view, HIV-positive status falls within that category.

[9] See generally Myron S. Cohen, *HIV and Sexually Transmitted Diseases*, 98 Postgraduate Medicine 52, 63 & Table 2 (1995) (compiling studies dating from 1987-1989 and concluding that "condoms appear to be very effective in preventing the spread of HIV").

can also be expected to prevent pregnancy, respondent must take additional and special steps to become pregnant —steps that most other individuals need not undertake.

Even more significantly, respondent's HIV infection substantially limits reproduction because it would pose a substantial risk to the life of a child. Respondent "faces an approximately 25% risk of transmitting the virus to her child without AZT therapy and an 8% risk of viral transmission with such therapy." Pet. App. 14a.[10] Individuals without HIV infection do not face that risk. As the court of appeals recognized, "[n]o reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity." *Ibid.*

HIV also substantially limits reproduction because, as the court of appeals noted (Pet. App. 15a), respondent likely would not live long enough to complete the task of

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[10] In our view, although the result would be the same regardless of which figure is used in the analysis, the 25% figure is the relevant one. Under Department of Justice and EEOC regulations, the determination of whether there is a substantial limitation of a major life activity "should be assessed without regard to the availability of mitigating measures, such as reasonable modifications or auxiliary aids and services." 28 C.F.R. Pt. 36 App. B, § 36.104, at 611 (DOJ regulations); 29 C.F.R. Pt. 1630 App., § 1630.2(j), at 351 (EEOC regulations). Even when an individual has been able to mitigate his or her disability by such measures, that individual remains subject to "deprivations based on prejudice, stereotypes, or unfounded fear." *School Bd. of Nassau County* v. *Arline*, 480 U.S. at 287. Because Congress intended to combat the use of such "stereotypic assumptions not truly indicative of the individual ability of [disabled] individuals to participate in, and contribute to, society," 42 U.S.C. 12101(a)(7), a narrow interpretation of the ADA that would withdraw coverage from such individuals would be inappropriate. The courts of appeals disagree regarding whether mitigating measures should be taken into account in determining whether an impairment amounts to a disability. See *Sutton* v. *United Air Lines, Inc.*, 130 F.3d 893, 901 & nn.7-8 (10th Cir. 1997) (citing cases).

raising a child if she chose to have one. Respondent was a 33-year-old woman at the time petitioner refused to provide her dental services. See Tr. 52 (deposition of respondent, May 16, 1995). As respondent herself testified, "the fact that [a] baby probably wouldn't have a mother after a while," Pet. App. 13a, necessarily imposed a severely limiting condition on her reproductive activity.

2. The ADA's definition of "disability"—including the term "major life activities"—was drawn virtually verbatim from the definition of the term "handicapped individual" in the Rehabilitation Act Amendments of 1974, Pub. L. No. 93-516, § 111, 88 Stat. 1619, 29 U.S.C. 706. At the time Congress enacted the ADA, the lower courts had uniformly construed the Rehabilitation Act to cover asymptomatic HIV-positive individuals.[11] A formal Department of Justice legal opinion had concluded that the Rehabilitation Act "protects symptomatic *and asymptomatic* HIV-infected individuals against discrimination * * * on the basis of any actual, past or perceived effect of HIV infection that substantially limits any major life activity." See Memorandum from Douglas W. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, to Arthur B. Culvahouse, Jr., Counsel to the President 1-2 (Sept. 27,

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[11] See *Doe* v. *Garrett*, 903 F.2d 1455, 1457 (11th Cir. 1990), cert. denied, 499 U.S. 904 (1991); *Cain* v. *Hyatt*, 734 F. Supp. 671, 677-678 (E.D. Pa. 1990) (under P.H.R.A.); *Baxter* v. *City of Belleville*, 720 F. Supp. 720 (S.D. Ill. 1989); *Thomas* v. *Atascadero Unified Sch. Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987); *Ray* v. *School Dist. of Desoto County*, 666 F. Supp. 1524 (M.D. Fla. 1987). More recent cases under the Rehabilitation Act have agreed. See, *e.g.*, *Gates* v. *Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994); *Doe* v. *District of Columbia*, 796 F. Supp. 559, 568 (D.D.C. 1992); *Glanz* v. *Vernick*, 756 F. Supp. 632, 635 (D. Mass. 1991); cf. *Austin* v. *Pennsylvania Dep't of Corrections*, 876 F. Supp. 1437, 1465 (E.D. Pa. 1995); *Leckelt* v. *Board of Comm'rs of Hosp. Dist. No. 1*, 714 F. Supp. 1377, 1385-1386 n. 4 (E.D. La. 1989), aff'd, 909 F.2d 820 (5th Cir. 1990).

1988) (Kmiec Memorandum) (footnote omitted; emphasis added), *reprinted in Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources*, 101st Cong., 1st Sess. 338-339 (1989). In reaching that conclusion, the opinion relied in part on the fact that HIV substantially limits the major life activity of reproduction (and of intimate sexual relationships). See Kmiec Memorandum 9-11.[12] When Con-

[12] The Kmiec memorandum stated that "we believe it is likely that the courts will conclude that asymptomatic HIV-infected individuals have an impairment that substantially limits certain major life activities." Kmiec Memorandum 10. Specifically, the memorandum stated that "we believe that it is reasonable to conclude that the life activity of procreation—the fulfillment of the desire to conceive and bear healthy children—is substantially limited for an asymptomatic HIV-infected individual." *Ibid*. The memorandum also stated that "some courts can be expected to find a limitation of a major life activity in the fact that an asymptomatic HIV-infected individual's intimate relations are also likely to be affected by HIV infection." *Id*. at 11. The memorandum noted that it may be argued that the HIV infection has not affected major life activities of individuals who have not changed their conduct as a result of the infection, but the memorandum reasoned that "in any case where the evidence indicates that the plaintiff HIV-infected individual has in fact changed his or her behavior—as, for example, where the plaintiff represents that procreation has been foregone—the court may well find a limitation of major life activity." *Ibid*. Finally, the memorandum noted that "courts may choose to pass over such factual questions since the Supreme Court has stated an alternative rationale for finding a life activity limitation based on the reaction of others to the infection." *Ibid*. With respect to that issue, the memorandum concluded that "the perceived impairment need not directly result in a limitation of a major life activity, so long as it has the indirect effect, due to the misperceptions of others, of limiting a life activity." *Id*. at 12.

Three years later, after enactment of the ADA, the Department of Justice promulgated its regulations interpreting the ADA. The Preamble to those regulations synthesizes the discussion in the Kmiec Memorandum to conclude that "asymptomatic HIV disease is an impairment that substantially limits a major life activity, either because

gress enacted the ADA two years later, the committee reports expressly stated that "a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships," relying on the discussion in the Kmiec Memorandum. H.R. Rep. No. 485, 101st Cong., 2d Sess. Pt. 2, at 52 (1990) (citing Kmiec memorandum); accord H.R. Rep. No. 485, *supra*, Pt. 3, at 28 n.18; S. Rep. No. 116, 101st Cong., 1st Sess. 22 (1989).[13]

When it adopted the coverage provision of the Rehabilitation Act for use in the ADA, Congress was thus fully aware that individuals with asymptomatic HIV were covered individuals under the Rehabilitation Act. Moreover, the legislative history of the statute expressly notes Congress's approval of the administrative construction to that effect. This Court has recognized that "[w]hen a Con-

of its actual effect on the individual with HIV disease or because the reactions of other people to individuals with HIV disease cause such individuals to be treated as though they are disabled." 28 C.F.R. Pt. 36 App. B, § 36.104, at 610. See App., *infra*, 6a. The Preamble goes on to explain that, for that reason, the regulations include "HIV disease (symptomatic or asymptomatic)" in the definition of "physical or mental impairment." See pp. 10-11, *supra*.

[13] Congress had studied the problem of discrimination against HIV-positive individuals in the process of drafting the ADA. The House and Senate committee reports, discussing the need for the legislation, noted that a Presidential Commission had "concluded that discrimination against individuals with HIV infection is widespread and has serious repercussions for both the individual who experiences it and for this nation's efforts to control the epidemic." H.R. Rep. No. 485, *supra*, Pt. 2, at 31; see also S. Rep. No. 116, *supra*, at 8. The reports noted the public health consequences of a failure to protect against such discrimination; individuals who fear discrimination "will be reluctant to come forward for testing, counseling, and care" and that failure "will undermine * * * efforts to contain the HIV epidemic." H.R. Rep. No. 485, *supra*, Pt. 2, at 31; S. Rep. No. 116, *supra*, at 8.

gress that re-enacts a statute voices its approval of an administrative or other interpretation thereof, Congress is treated as having adopted that interpretation, and [the courts are] bound thereby." *United States* v. *Board of Comm'rs*, 435 U.S. 110, 134 (1978).[14] Petitioner's arguments that the terms of the ADA should be construed to leave such individuals outside the Act's protections should therefore be rejected.

3. Petitioner suggests (Br. 39-41) that HIV infection does not substantially limit reproduction within the meaning of the Act because it is the individual's reaction to the impairment, and not the impairment itself, that limits the activity. That distinction is immaterial. Petitioner's view appears to be that an impairment may be said to "substantially limit" a major life activity only if the impairment entirely eliminates the ability to engage in that activity, thus leaving no choice to the individual. There is no basis in the text, legislative history, or regulatory interpretation of the statute for that interpretation. In addition, as noted above, it is the physiology of the HIV virus—not any "choice" of respondent—that would threaten the life of a man engaging in unprotected intimate sexual activity with her, that would threaten the life of her child if she should become pregnant, and that substantially shortens her life expectancy. Regardless of whether respondent chooses to engage in reproduction under these conditions, the "major life activity" of reproduction is for her substantially limited "in comparison to most people."[15] 28 C.F.R. Pt. 36 App. B, § 36.104, at 611; see *Runnebaum*, 123 F.3d at 184-185 (Michael, J., dissenting).[16]

[14] Consistent with Congress's intent, most of the decisions addressing whether persons with asymptomatic HIV are protected by the ADA have agreed with the court below that they are, although they have relied on a variety of theories. See generally *Hernandez* v. *Prudential Ins. Co.*, 977 F. Supp. 1160, 1163-1165 (M.D. Fla. 1997) (discussing cases); *Hoepfl* v. *Barlow*, 906 F. Supp. 317, 319 n.7 (E.D. Va. 1995). In one case holding that an HIV infected person was not disabled under the employment provisions of the ADA, the court found that the plaintiff failed to establish that he had experienced any limitation as a result of the impairment. *Cortes* v. *McDonald's Corp.*, 955 F. Supp. 541, 546-547 (E.D.N.C. 1996).

[15] Petitioner states (Br. 41) that "[w]omen in abject poverty or violent neighborhoods confront in their reproductive decision-making risks just as significant that they and their babies will live short and miserable lives," and suggests that respondent should be treated no differently from such women. The comparison is inapt. Unlike those situations, the limitations on respondent's reproduction are the result of a physical impairment. As the ADA's definition of disability makes clear, it is such limitations—and not those that result from poverty or poor neighborhoods—that Congress sought to address in the ADA. See 28 C.F.R. Pt. 36 App. B, § 36.104, at 610 ("Physical or mental impairment" does not include "environmental, cultural, economic, or other disadvantages, such as having a prison record, or being poor.").

[16] For the reasons given above, we believe that, pursuant to the first prong of the ADA definition of disability, respondent was disabled because her HIV infection substantially limited a major life activity. If this Court were to disagree, however, the case should be remanded to resolve whether respondent is disabled under the third prong of the ADA definition of disability, which requires a showing that she was "regarded as having such an impairment." 42 U.S.C. 12102(2)(C). The court of appeals did not reach that issue, but respondent has stated that it was properly raised below. See Pet. App. 6a n.2; see also Br. in Opp. 4 n.4. Irrational exclusion of persons such as respondent from activities and services due to fear of contagiousness would establish that such persons are "regarded as" disabled under 42 U.S.C. 12102(2)(C). See H.R. Rep. No. 485, *supra*, Pt. 2, at 31; S. Rep. No. 116, *supra*, at 8, 24; *Cain* v. *Hyatt*, 734 F. Supp. 671, 678-680 (E.D. Pa. 1990).

II. AN ASYMPTOMATIC HIV-INFECTED PATIENT DOES NOT POSE A "DIRECT THREAT" TO DENTAL HEALTH CARE WORKERS FOLLOWING UNIVERSAL PRECAUTIONS WHEN PERFORMING ROUTINE DENTAL CARE

1. The ADA does not require a public accommodation to serve an individual who "poses a direct threat to the health or safety of others." 42 U.S.C. 12182(b)(3). In this context, "direct threat" means "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures." *Ibid.* As was true of a similar provision in the Rehabilitation Act discussed by this Court in *Arline*, such an exception serves the interest in "avoiding exposing others to significant health and safety risks." 480 U.S. at 287. At the same time, however, any test for determining whether an individual poses a "direct threat" must be carefully circumscribed "if [the Rehabilitation Act] is to achieve its goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear" (*ibid.*)—a goal shared by the ADA. See H.R. Rep. No. 485, *supra*, Pt. 2, at 53; *id.*, Pt. 3, at 30. To satisfy those concerns, the Court in *Arline* adopted a test that relied exclusively on objective factors regarding the risk and normally required deference to the judgments of public health officials. *Arline*, 480 U.S. at 288.

Congress included the "direct threat" exception in the ADA, and incorporated "the same standard as articulated by the Supreme Court in [*Arline*]." H.R. Rep. No. 485, *supra*, Pt. 3, at 45; accord *id.*, Pt. 2, at 76. The Department of Justice Regulations implementing Title III of the ADA similarly "codif[y] the standard first applied by the Supreme Court in [*Arline*]." 28 C.F.R. Pt. 36 App. B, § 36.208, at 626. In keeping with *Arline*, any determination that an

individual poses a "direct threat" must rely on "an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence." 28 C.F.R. 36.208(c). See App., *infra*, 4a-5a. That assessment must consider: "the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk." *Ibid.* To protect against the exclusion of individuals based on fear or stereotype, the "direct threat" provision requires the existence of a "significant" risk, "not a speculative or remote risk." H.R. Rep. No. 485, *supra*, Pt. 2, at 56. A showing that a plaintiff does not pose a direct threat does not require a showing that the plaintiff poses no risk, see *id.*, Pt. 3, at 46 (emphasis added) (citing *Chalk* v. *United States Dist. Court*, 840 F.2d 701, 707-708 (9th Cir. 1988)), for risks are inherent in daily life—particularly in a field like dentistry, where "[w]ell before the advent of HIV, [dental health care workers] were at risk of acquiring occupationally a number of diseases, from the common cold to potentially lethal Hepatitis B and TB." J.A. 107.

2. The Court in *Arline* stated that in making the necessary findings, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288; see 28 C.F.R. Pt. 36 App. B, § 36.208, at 626; see also H.R. Rep. No. 485, *supra*, Pt. 3, at 45 ("Such risk of transmitting the infection to others must be determined based on objective and accepted public health guidelines."). The court of appeals interpreted that language (Pet. App. 21a) to mean that the views of public health officials are to be given "prima facie force," but that those views may be rebutted "by persuasive evidence adduced from other recognized experts in a given field." We agree. Under that rule, where, as here, the medical issue (*i.e.*, risk of contagion) is not within the expertise of the health care

provider (*i.e.*, the dentist), but rather is within the expertise of public health experts, there is no reason to defer to the views of the particular health care provider. Public health organizations and experts have the resources and expertise to evaluate the risk of infection; when they have examined the question and made the reasonable judgment that a practice can be engaged in safely, the courts should defer to that judgment—particularly where, as here, it is substantially unrebutted.

Reliance on such a specialized, objective judgment prevents decisions from turning on litigating adversaries' selective excerpts from medical materials, and therefore limits the risk that unjustified fears or stereotypes will distort the decision making process. Moreover, deference to the reasonable judgment of public health authorities is appropriate even if some uncertainties remain, for "[l]ittle in science can be proved with complete certainty." *Chalk*, 840 F.2d at 707. "Confronted with some uncertainties about scientific truth, judges, perhaps above all others, should act on the basis of that which *is* known, or, where this is not possible, on the basis of that which those best qualified to speak *say* is known." *Id.* at 712 (Sneed, J., concurring).

3. In this case, the court of appeals properly deferred to "those best qualified to speak" on the subject. Because petitioner did not demonstrate that the CDC's judgment was medically unreasonable, the district court properly granted summary judgment on the "direct threat" question.

The Centers for Disease Control and Prevention (CDC) has assessed the medical evidence concerning the risk that dentists can contract HIV from their patients. The CDC has adopted recommended infection-control practices—so-called "universal precautions"—for dentistry under which *all* patients are to be treated as if they carry an infectious or blood-borne disease such as HIV. Dentists cannot always know whether their patients carry such diseases—indeed, not all patients who carry infectious diseases know that they are infected. Refusing to treat the patients who both know that they are infected and inform the dentist of that fact is therefore not an effective way of reducing the risk. See J.A. 268, 274-275.[17]

The CDC has found the risk of HIV transmission in the dental context "so low as to be unquantifiable," and the universal precautions it recommends further reduce that already low risk. J.A. 283 (Declaration of then-Director of the Oral Health Program at the CDC); see also J.A. 268 (expert testimony that "the risk of infection to the health care worker [from a patient] is infinitesimally small, less than the risk of death involved in driving a car or being struck by lightning"). Although there have been very rare cases of transmission from patients to non-dental health care workers,[18] the precautions available to such workers

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[17] Indeed, one expert testified that adopting a policy of refusing to treat patients who acknowledge their infectious status "may actually be creating a more risky environment," since a dentist who "believ[es] he has eliminated a risk [in that manner] * * * may become less stringent in his practice of infection control." J.A. 274-275.

[18] As of December 31, 1994, the CDC was aware of 42 non-dental health care workers "documented as having seroconverted to HIV following occupational exposures to HIV"; 36 of these cases involved percutaneous exposures such as needlesticks. J.A. 106. Whether a needlestick injury leads to infection depends significantly on the amount of blood transmitted; the narrow-bore needles typically used in routine dentistry make it less likely that an amount of blood sufficient to cause infection will be transmitted in the dental context. J.A. 106-107. As Dr. Donald Marianos, then-Director of the Division of Oral Health at the CDC, explained, "[b]ecause the size of anesthetic needles used in dentistry is much smaller than that used in most medical settings, the majority of needlesticks among dental workers will involve smaller, rather than larger amounts of HIV infected blood. It is the position of the CDC that the risk of acquiring HIV occupationally from a needlestick in the dental setting is so low that it cannot be accurately quantified." J.A. 278-279. Moreover, the use of "instruments instead of

together with the nature of dental practice, explain why there has never been a documented case of HIV transmission from infected patient to dental health care worker.[19] Pet. App. 25a; see J.A. 56, 88, 106. The CDC thus has taken the position that "it is safe to provide dental care to patients with AIDS * * * in private dental offices when universal precautions are utilized." J.A. 284.

The CDC's conclusion is in accord with the positions of other professional and public health organizations, including the American Dental Association. J.A. 225.[20] That po-

fingers to retract tissue or guide anesthetic needles during injections" can reduce the risk of accidental dental needlestick incidents, and "self-sheathing anesthetic syringes are now available to prevent needlestick injuries during or after anesthetic injections." J.A. 270.

[19] We agree with the court of appeals that the medical evidence in cases of this type should be "confin[ed] * * * to that available at the time a dentist or other health-care professional refuses to treat." Pet. App. 18a (citing 28 C.F.R. 36.208(c)). Nonetheless, we are informed by the CDC that, as of the end of 1997, there remains no documented case of transmission of the HIV virus from a patient to a dental health care worker.

[20] Although the American Dental Association has filed an amicus brief in this Court in support of petitioner, it does not address the "direct threat" issue. The brief (at 2) does make clear, however, that it "does not in any way challenge or undermine longstanding Association policy concerning the safety of the dental office and/or the treatment of HIV-infected individuals." The brief reaffirms, therefore, that in light of the efficacy of universal precautions, "[p]atients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed," J.A. 225, and that "a patient's HIV/AIDS status is not a justification for refusal of treatment." Amer. Dental Ass'n Amicus Br. 2-3 n.2; see J.A. 225-226. Indeed, the Association's Council on Ethics, Bylaws and Judicial Affairs has stated that it is unethical to refuse treatment to those who are HIV infected. See J.A. 228 ("A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical."). Refusal to treat HIV-infected patients has similarly been declared unethical by the American Association of Oral and Maxillofacial Surgeons, J.A. 111, the Association of State and Territorial Health Officials and Association of State and Territorial Dental Directors, J.A. 125-126, and the American Association of Dental Schools, J.A. 134.

sition certainly constitutes a "reasonable medical judgment[]," *Arline*, 480 U.S. at 288, and is therefore entitled to deference from the courts. *Ibid.* See also *American Dental Ass'n* v. *Martin*, 984 F.2d 823, 828 (7th Cir.) (stating that the CDC's judgments regarding precautions to prevent the spread of bloodborne pathogens "are entitled to respect by the nonspecialist, biomedically unsophisticated Article III judiciary"), cert. denied, 510 U.S. 859 (1993). Because the probability of transmission in the course of routine dental care is so extraordinarily low (and would not in any event be eliminated), even the severe consequences of contracting HIV are not sufficient to establish the existence of a "significant risk to the health or safety of others." 42 U.S.C. 12182(b)(3).[21]

[21] Key differences between HIV-infected *doctors* and HIV-infected *patients* render the cases involving HIV-infected health-care workers inapposite. See, *e.g.*, *Doe* v. *University of Maryland Med. Sys. Corp.*, 50 F.3d 1261, 1265-1266 (4th Cir. 1995) (hospital did not violate ADA by suspending HIV-positive neurosurgical resident and offering him alternative residencies in nonsurgical fields); *Bradley* v. *University of Texas M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924-925 (5th Cir. 1993) (hospital did not violate Rehabilitation Act by reassigning HIV-positive surgical assistant to procurement department), cert. denied, 510 U.S. 1119 (1994). See also J.A. 107 (discussing the single case of transmission of HIV from dentist to six of his patients), C.A. App. 211-212 (same). The CDC has recommended that medical institutions make their own case-by-case determinations regarding whether particular HIV-infected health care workers can perform exposure-prone invasive procedures. See *University of Maryland*, 50 F.3d at 1266; *Bradley*, 3 F.3d at 924; *Leckelt* v. *Board of Comm'rs*, 909 F.2d 820, 828, 830 (5th Cir. 1990). Thus, although we take no position on the results reached on the facts of each of the cited cases, they are fully consistent with giving deference to the reasonable judgments of public health officials. In

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
BILL LANN LEE
Acting Assistant Attorney General
LAWRENCE G. WALLACE
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General
JESSICA DUNSAY SILVER
THOMAS E. CHANDLER
Attorneys

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addition, patients and doctors are not similarly situated. Since patients cannot control whether infected health care providers scrupulously employ universal precautions, patients bear all of the risk of transmission without having any ability to assure that the risk is minimized.

APPENDIX

STATUTORY AND REGULATORY PROVISIONS

1. 42 U.S.C. 12102 provides in pertinent part:

Definitions

* * * * *

(2) Disability

The term "disability" means, with respect to an individual—

(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment.

* * * * *

2. 42 U.S.C. 12186 provides in pertinent part:

Regulations

* * * * *

(b) Other provisions

Not later than 1 year after July 26, 1990, the Attorney General shall issue regulations in an accessible format to carry out the provisions of this subchapter not referred to in subsection (a) of this section that include standards applicable to facilities and vehicles covered under section 12182 of this title.

3. 28 C.F.R. 36.104 provides:

For purposes of this part, the term—

* * * * *

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

(1) The phrase **physical or mental impairment** means—

(i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine;

(ii) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities;

(iii) The phrase **physical or mental im-pairment** includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism;

(iv) The phrase **physical or mental impairment** does not include homosexuality or bi-sexuality.

(2) The phrase **major life activities** means functions such as caring for one's self, performing manual

tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(3) The phrase **has a record of such an impairment** means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(4) The phrase **is regarded as having an impairment** means—

(i) Has a physical or mental impairment that does not substantially limit major life activities but that is treated by a private entity as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by a private entity as having such an impairment.

4. 28 C.F.R. 36.208 provides:

(a) This part does not require a public accommodation to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of that public accommodation when that individual poses a direct threat to the health or safety of others.

(b) Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a

modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.

(c) In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

5. 28 C.F.R. Pt. 36, App. B, provides in pertinent part:

Test A—A Physical or Mental Impairment That Substantially Limits One or More of the Major Life Activities of Such Individual

Physical or mental impairment. Under the first test, an individual must have a physical or mental impairment. As explained in paragraph (1) (i) of the definition, "impairment" means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs (including speech organs that are not respiratory, such as vocal cords, soft palate, and tongue); respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine. It also means any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. This list closely tracks the one used in the regulations for section 504 of the Rehabilitation Act of 1973 (see, *e.g.*, 45 CFR 84.3(j)(2)(i)).

* * * * *

It is not possible to include a list of all the specific conditions, contagious and noncontagious diseases, or infections that would constitute physical or mental impairments because of the difficulty of ensuring the comprehensiveness of such a list, particularly in light of the fact that other conditions or disorders may be identified in the future. However, the list of examples in paragraph (1)(iii) of the definition includes: Orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

The examples of "physical or mental impairments" in paragraph (1)(iii) are the same as those contained in many section 504 regulations, except for the addition of the phrase "contagious and noncontagious" to describe the types of diseases and conditions included, and the addition of "HIV disease (symptomatic or asymptomatic)" and "tuberculosis" to the list of examples. These additions are based on the ADA committee reports, caselaw, and official legal opinions interpreting section 504. In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), a case involving an individual with tuberculosis, the Supreme Court held that people with contagious diseases are entitled to the protections afforded by section 504. Following the *Arline* decision, this Department's Office of Legal Counsel issued a legal opinion that concluded that symptomatic HIV disease is an impairment that substantially limits a major life activity; therefore it has been included in the definition of disability under this part.

The opinion also concluded that asymptomatic HIV disease is an impairment that substantially limits a major life activity, either because of its actual effect on the individual with HIV disease or because the reactions of other people to individuals with HIV disease cause such individuals to be treated as though they are disabled. See Memorandum from Douglas W. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, Department of Justice, to Arthur B. Culvahouse, Jr., Counsel to the President (Sept. 27, 1988), *reprinted in Hearings on S. 933, the Americans with Disabilities Act, Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources*, 101st Cong., 1st Sess. 346 (1989). The phrase "symptomatic or asymptomatic" was inserted in the final rule after "HIV disease" in response to commenters who suggested that the clarification was necessary to give full meaning to the Department's opinion.

* * * * *

Physical or mental impairment does not include simple physical characteristics, such as blue eyes or black hair. Nor does it include environmental, cultural, economic, or other disadvantages, such as having a prison record, or being poor. Nor is age a disability. Similarly, the definition does not include common personality traits such as poor judgment or a quick temper where these are not symptoms of a mental or psychological disorder. However, a person who has these characteristics and also has a physical or mental impairment may be considered as having a disability for purposes of the Americans with Disabilities Act based on the impairment.

Substantial limitation of a major life activity. Under Test A, the impairment must be one that "substantially limits a major life activity." Major life activities include such things as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. For example, a person who is paraplegic is substantially limited in the major life activity of walking, a person who is blind is substantially limited in the major life activity of seeing, and a person who is mentally retarded is substantially limited in the major life activity of learning. A person with traumatic brain injury is substantially limited in the major life activities of caring for one's self, learning, and working because of memory deficit, confusion, contextual difficulties, and inability to reason appropriately.

A person is considered an individual with a disability for purposes of Test A, the first prong of the definition, when the individual's important life activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people. A person with a minor, trivial impairment, such as a simple infected finger, is not impaired in a major life activity. A person who can walk for 10 miles continuously is not substantially limited in walking merely because, on the eleventh mile, he or she begins to experience pain, because most people would not be able to walk eleven miles without experiencing some discomfort.

* * * * *

The question of whether a person has a disability should be assessed without regard to the availability of mitigating measures, such as reasonable modifications or auxiliary aids and services. For example, a person with hearing loss is substantially limited in the major life activity of hearing, even though the loss may be improved through the use of a hearing aid. Likewise, persons with impair-

ments, such as epilepsy or diabetes, that substantially limit a major life activity, are covered under the first prong of the definition of disability, even if the effects of the impairment are controlled by medication.

(6)

No. 97-156

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF *AMICUS CURIAE* OF THE PROMINA NORTHWEST HEALTH SYSTEM IN SUPPORT OF PETITIONER

LIONEL J. POSTIC
Counsel of Record
STAN D. BABB
ROGER N. WILES
POSTIC & BABB, LLC
191 Roswell Street
Suite 100
Marietta, Georgia 30060
(770) 795-9003

Counsel for Amicus Curiae
Promina Northwest Health System

January 9, 1998

PRESS OF BYRON S. ADAMS ✦ WASHINGTON, D.C. ✦ 1-800-347-8208

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INTEREST OF AMICUS CURIAE[1]

Amicus Curiae, Promina Northwest Health System is a community-owned and operated network of hospitals, physicians and services providing our communities with high-quality health services in a cost-effective manner. Our network includes Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals: PROMINA Northwest Physicians Group, Medical Centers; Neighborhood Healthcare Centers; Health Place; Health Services; Hospice; and Atherton Place. Promina Northwest submits this brief to supplement the argument made by petitioner on the issues of: whether HIV is a per se disability; and whether the courts should defer to the judgments of health care providers who treat persons who are covered by the Americans with Disabilities Act because of an infectious disease such as HIV. This is important to Promina Northwest because any decision will impact all health care providers associated with it.

SUMMARY OF ARGUMENT

Respondent brought this lawsuit against Petitioner, a dentist, when he refused to treat her in his office and fill a cavity in one of her teeth because she is HIV-positive. Petitioner then offered to treat Respondent at a local hospital, which Respondent refused. This litigation ensued. Although Respondent is asymptomatic and the HIV does

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[1] Petitioner and respondent have consented to the filing of this amicus brief. Their letters of consent are being lodged with the Clerk. Pursuant to Rule 37.6 of the Rules of the Supreme Court of the United States, Amicus Curiae hereby submits that its counsel authored the present brief and that no party other than Amicus Curiae made any monetary contribution to the preparation of submission of this brief.

not affect her in any life function such as caring for herself, walking, seeing, or hearing, she claims that she is disabled and afforded protection under the Americans with Disabilities Act ("ADA"). She alleges that her condition limits her in the major life activity of reproduction because she has chosen not to bear children.

Respondent's condition is neither a disability per se under the ADA nor is it a disability under the first prong of the ADA's definition of disability. Under that prong, she must show that her physical impairment substantially limits her in a major life activity. Her subjective belief that she should not bear children when there exists no physiological barrier to do so does not constitute a substantial limitation on the life activity of reproduction. Moreover, to hold that HIV is a disability per se means that the substantially limitation language contained in the definition is mere verbage when dealing with HIV-positive individuals.

HIV positive patients pose a direct threat to health care providers. That the risk of infection is low does not negate the catastrophic consequences should the health care provider contract HIV from an infected patient. Health care service providers are unique and deserve special protection under the ADA, particularly in the area of deferring to the reasonable medical judgments of those providers in treating individuals with infectious diseases, such as HIV.

ARGUMENT

I. RESPONDENT IS NOT COVERED BY THE AMERICANS WITH DISABILITIES ACT BECAUSE SHE DOES NOT HAVE A DISABILITY.

The ADA defines "disability" as follows:

> The term "disability" means, with respect to an individual—
>
> A. a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
>
> B. a record of such an impairment; or
>
> C. being regarded as having such an impairment.[2]

The definition "provides no express guidance as to whether an HIV infected person comes within the ambit of the Act."[3] Respondent argues that she has a disability as that term is used in the ADA. She does not have a disability.

The first prong of the definition of "disability" requires that Respondent show: (1) she has a physical or mental impairment; (2) that condition impairs a major life function; and (3) the impairment is a substantial limitation on that major life activity. Respondent has alleged that she

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[2] 42 U.S.C. § 12102(2). The definition of "disability" is substantially similar to the definition of "handicapped individual" contained in Section 504 of the Rehabilitation Act of 1973, which states that a "handicapped individual" is "[A]ny person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment." 29 U.S.C. § 706(7)(B).

[3] *Doe v. Kohn Nast & Graf, P.C.*, 862 F. Supp. 1310, 1319 (E.D. Pa. 1994).

is disabled because she has a physical impairment, asymptomatic HIV, that substantially affects a major life activity, reproduction.[4] Amicus Curiae does not dispute Respondent's allegations that asymptomatic HIV is a physical impairment, or her allegation that reproduction is a major life activity.[5] Respondent's subjective belief that she should not bear children fails to constitute a substantial limitation on reproduction when there is no physiological barrier to reproduction.

The definition of disability under the ADA is substantially similar to the definition of "handicapped

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[4] It is unclear from the opinion of the U.S. Court of Appeals for the First Circuit whether Respondent as asserted that she is disabled under the "regarded as" prong of the definition of disability. Because it has been alleged that being HIV-positive is a disability under the third prong of the definition, this Brief will address that aspect of the definition of disability as applied under Title III to persons who are HIV-positive.

[5] Whether reproduction is a major life activity is a hotly contested issue. There is a split among the courts whether reproduction constitutes a major life activity. The following cases have held that reproduction is not a major life activity: *Krauel v. Iowa Methodist Medical Center*, 915 F. Supp. 102 (S.D. Iowa 1995) (Reproduction is not a major life activity under the Americans with Disabilities Act—"We conclude ... that to treat reproduction and caring for others as major life activities under the ADA would be inconsistent with the illustrative list of activities in the [EEOC's] regulations and a considerable stretch of federal law."), *aff'd*, 95 F.3d 674 (8th Cir. 1996); *Zatarin v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd*, 79 F.3d 1143 (5th Cir. 1996). The following cases have held that reproduction is a major life activity: *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393, 1404 (N.D. Ill. 1994); *Doe v. Kohn Nast & Graf, P.C.*, 862 F. Supp. 1310, (E.D. Pa. 1994).

individual" under the Rehabilitation Act of 1973.[6] HIV-positive plaintiffs have brought cases alleging discrimination under both Acts, offering little or no explanation of how being HIV-positive substantially limits them in a major life activity or even the life activity that is affected by being HIV-positive.[7]

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[6] *Ennis v. National Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 57 (4th Cir. 1995) (decided under Title I); *Tyndall v. National Educ. Ctr., Inc.*, 31 F.3d 209, 213 n. 1 (4th Cir. 1994). The definition of "handicapped individual" is set forth in footnote 2, *supra*.

[7] The EEOC regulations under Title I of the ADA state that an individual faces a substantial limitation when he or she is:

(1) The term substantially limits means:
(i) Unable to perform a major life activity that the average person in the general populations can perform; or
(ii) Significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform the same major life activity.
(2) The following factors should be considered in determining whether an individual is substantially limited in major life activity:
(i) The nature and severity of the impairment;
(ii) The duration or expected duration of the impairment; and
(iii) The permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment.

29 C.F.R. § 1630.2(j). The EEOC unnecessarily confuses the issue of disability by using the term "impairment" which is also used in the definition of disability without providing a clear explanation between the manner in which it is used in the definition and how it is used in

And, although some courts have held that either HIV is not a disability per se,[8] or is not a disability at all,[9] the majority of the courts, the Equal Employment Opportunity Commission ("EEOC"), in its regulations under Title I of the ADA,[10] and the U.S. Department of Justice ("DOJ"), in its regulations under Title III of the ADA,[11] have all consistently held that HIV is a disability under both the Rehabilitation Act, and the Americans with Disabilities Act with no analysis of the substantial limitation

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explaining substantial limitation. The duration of the impairment apparently is intended to mean how long the person is prevented from engaging in the major life activity because of the physical or mental impairment.

[8] *See Ennis v. National Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.2d 55 (4th Cir. 1995) (holding under Title I of the ADA that HIV-positive status is not a per se disability, but should, as with all physical and mental impairments, be determined on a case-by-case basis).

[9] *Runnebaum v. NationsBank of Md., N.A.*, 123 F.3d 156, 174 (4th Cir. 1997).

[10] The EEOC stated in its regulations, under Title I, that whether a physical or mental impairment substantially limits a major life activity is dependent on the effect on the particular individual in most cases. The regulation states that "Some impairments may not be disabling for particular individuals but not for others." Then the regulations states, without explanation, that "Other impairments, however, such as HIV infection, are inherently substantially limiting." 29 C.F.R. Pt. 1630, App. § 1630.2(j) (1996).

[11] The DOJ regulations list "HIV disease (whether symptomatic orasymptomatic)" as one among a number of diseases and conditions that constitute physical or mental impairments under the ADA without analyzing how asymptomatic HIV substantially limits a major life activity. *See* 28 C.F.R. § 36.104 (1)(iii).

requirement.[12] In the case of the EEOC and DOJ regulations being HIV-positive is a disability per se.[13]

Those regulations are contrary to the statutory language of the ADA and fail to give meaning to the substantial limitation requirement when dealing with HIV-positive individuals. The Act clearly requires an analysis of substantial limitation in determining whether a disease or condition is a disability. To hold otherwise in the case of HIV-positive individuals, and ignore the statutory language, would be tantamount to striking the substantial limitation language from the Act with respect to those cases.

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[12] The EEOC regulations state that HIV is a disability. 28 C.F.R. § 35.104(4)(l)(ii).

The following courts have held that HIV is either a handicap under the Rehabilitation Act or a disability under the Americans with Disabilities Act: *Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994); *Harris v. Thigpen*, 941 F.2d 1495, 1522-24 (11th Cir. 1991) (HIV positive is a handicap under the Rehabilitation Act because the defendant regarded the plaintiffs, prisoners, as having a physical or mental impairment amounting to a handicap and treated all of them as such by segregating them and treating them differently); *United States v. Morvant*, 898 F. Supp. 1157, 1161 (E.D. La. 1995) (Both persons who have AIDS and are HIV-positive have a disability under Title III because the U.S. Department of Justice include them as disabilities in the Title III regulations; no analysis of definition of disability done); *Doe v. Kohn Nast & Graf, P.C.*, 862 F. Supp. 1310, 1319-21 (E.D. Pa. 1994) (This court analyzed that HIV is a physical impairment and that reproduction is a major life activity, but failed to indicate how the plaintiff was substantially limited in that major life activity).

[13] The decision to include asymptomatic HIV as a disability per se under the DOJ regulations was based on an opinion letter written by then Acting Assistant Attorney General in the DOJ's Office of Legal Counsel. 28 C.F.R. App. A § 36.104.

Respondent must, therefore, show that being HIV-positive substantially limits, i.e., significantly restricts, her ability to reproduce.[14] Respondent articulates no physiological reason that she is unable to reproduce. That she is HIV-positive does not preclude reproduction.[15]

Rather, she argues she is substantially limited in reproduction because she has chosen not to bear children. She has made this choice because she does not want to pass HIV to her child. This conscious choice to not engage in an activity that may amount to a major life activity cannot be what the drafters of the ADA intended to protect.

Respondent also has argued that she has chosen not to bear children because she would not be alive to raise those children. That reason does not impact on her ability to reproduce. At most, it impacts on the ability to care for others, which is not included in the illustrative list of major life activities.[16]

To allow persons to choose for themselves that some physical or mental impairment substantially affects reproduction would transform an objective standard into a subjective one. That standard should not be whether a person with any physical or mental impairment makes a

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[14] *Forrisi v. Bowen*, 794 F.2d 931, 933-34 (4th Cir. 1986).

[15] More than 7000 children per year are born to women who have tested HIV-positive. 43 Morbidity & Mortality Weekly Report 285 (1994).

[16] The U.S. Department of Justice regulations under Title III state that "major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 36.104(2).

conscious decision not to reproduce when no physiological reason precludes him or her from doing so. Such a standard would allow any person with a physical or mental impairment to claim he or she is disabled. For instance, an individual who has a history of diabetes, but is not substantially limited in a life activity, would be disabled under the ADA if she makes a conscious decision not to bear children because she might pass on the genetic trait of diabetes to those children. The same could be said about a number of other potentially genetically transmitted diseases.

The drafters of the ADA could not have intended to make a condition or a disease a per se disability solely because of the individual's choice not to reproduce. To hold otherwise, trivializes other disabilities such as blindness and deafness that are more akin to a per se disability because they are conditions over which the individual has no control and that clearly affect major life activities. This Court should hold that asymptomatic HIV is not a per se disability, and Respondent is not disabled under the ADA.

II. HIV-POSITIVE PATIENTS POSE A DIRECT THREAT OF HARM TO HEALTH CARE WORKERS AND DEFERENCE SHOULD BE ACCORDED THE PROFESSIONAL JUDGMENT OF THOSE WORKERS IN THEIR DECISIONS TO TREAT SUCH PATIENTS.

Under the ADA, a dentist's office, or any other place of public accommodation, must serve all disabled persons without reference to their disabilities unless the covered service provider is dealing with a person who "poses a direct threat to the health and safety of others."[17]

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[17] 42 U.S.C. § 12182(b)(3).

In the seminal case on this issue, this Court required in *School Board of Nassau County v. Arline*,[18] that the court should "achieve its goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns of grantees as avoiding exposing others to significant health and safety risks."[19]

In attempting to follow the *Arline* decision, the First Circuit defers to the judgment of public health officials and not health care professionals in determining the best available objective evidence regarding "direct threat." The court emphasized that the applicable regulations require a risk judgment based on "current medical knowledge or on the best available evidence."[20] The First Circuit found the best objective evidence for determining risk at the Center for Disease Control and accorded no deference to Dr. Bragdon's medical judgment. This Court held in *Arline* that "courts normally should defer to the reasonable medical judgments of public health officials."[21] What a court "normally" should do is qualified by Footnote 18 in the same case where this Court said "This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians . . .."[22] The Court should now expand

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18 480 U.S. 273 (1987).

19 *Id.* at 287.

20 28 C.F.R. § 36.208(c).

21 480 U.S. at 288.

22 *Id.* at 288 n.18.

the *Arline* decision to include deference to private health care professionals.

The EEOC codified normalcy when drafting ADA regulations.[23] The First Circuit followed the codification on this issue of deference to public officials over the private medical judgments of health care professionals.[24] The court also ignored the uniqueness of health care in the scheme of public accommodation and the variant nature of HIV itself. In this HIV debate, public health officials should not be considered the final arbiter of what is objectively medically best and necessary because of the contingent and immediate nature of health care. In fact, at any given time public health officials may be the best, or the worst, people to determine "direct threat."

Take for example the facts in *Arline*. Public health officials were precisely the proper people to determine a significant risk. The events surrounding the case took place in a public school. The official duty of the public health workers in Nassau County was to protect the public health in a public situation where a contagious disease could be spread. It makes perfect and logical sense for a public health official to make determinations under those sets of facts. That is not the case when health care professionals are at work rendering service to the community. Health care professionals have independent knowledge and resources involving risk from their own professional experience, journals, seminars, and societies. The treatment of HIV in a health care situation shifts the risk of infection from the public to the health care worker.

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23 *See* 28 C.F.R. Pt.36, App. B § 36.208 (1996).

24 *Abbott v. Bragdon*, 107 F.3d 944 (1st Cir. 1997)

Competence and credibility do not always accompany public health determination. For example, at the initial outbreak of the AIDS epidemic public health officials refused to shut down bath houses in San Francisco in the face of political pressure. Public health officials are not immune from political pressure and influence in their pronouncements. Public policy should allow decision making on private health care issues by trained medical and dental professionals. The very nature of health care service necessitates the need for health care professionals to be free to make informed determinations of how, when, and where treatment takes place without yielding to the "prima facie force . . . of public health authorities."[25]

That the HIV virus changes and mutates makes treatment difficult and a cure distant. Accurate and available medical evidence today may not be accurate and available tomorrow. Health care professionals must be allowed to rely on all medical information and their professional judgment regarding the specifics of treatment.

If the statistics are right, the probability of contracting HIV by health care providers from an infected patient .3%.[26] However, "the factors that influence this

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[25] *Id.* at 945.

[26] D. Cardo, D. Culver, C. Ciesielski, P. Srivastava, R. Marcus, D. Abiteboul, J. Heptonstall, G. Ippolito, F. Lot, P. McKibben, D. Bell, the Centers for Disease Control, and Prevention Needlestick Surveillance Group, *A Case-Control Study of HIV Seroconversion in Health Care Workers After Percutaneous Exposure*, 337 N. Eng. J. Med. 1485, 1485 (1997).

risk are not well understood."[27] As of June, 1995, the Center for Disease Control had documented that 46 health care professionals had been infected with HIV on the job, and that another 97 health care workers who were HIV-positive had been infected as a result of occupational transmission.[28] Unfortunately, the person who consequentially falls in that statistically fatal .3%, dies!

In *Abbott* the First Circuit disregarded the risk claims of Dr. Bragdon as ". . . too speculative and tangential."[29] This evidences the utilitarian aspects of the court's ruling. The potential loss of a health care worker appears to be worth the price of Respondent having her teeth filled conveniently. Why? If this debate were solely on the issue of public health, the goal would be elimination of the health care threat, not the minimization of risks to the health care provider. Conversely, as a civil rights matter, some would contend that potential discrimination must be guarded against even at the risk of human life. Yet, health care professionals are singled out at a rate of approximately three in every thousand as a potential sacrifice on the altar of political correctness and expediency.

Amicus Curiae asks the court to revisit *Arline*, not only to decide the issue of whether the court should "also

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[27] *Id.*

[28] American Medical News, Feb. 5, 1996, <www.ama-assn.org/special/hiv/newsline/special/amnsty.htm>, at 3. The report indicates that the numbers of HIV-positive health care workers is probably under reported. *Id.* at 3-4.

[29] *Abbott*, 107 F.3d at 948.

defer to the reasonable judgments of private physicians,"[30] but to determine the fundamental fairness of forcing doctors, dentists, and other health care workers to take a small but deadly risk by the coercive force of law. Requiring a health care worker to treat a patient is not the same as mandating a business to provide access and service. A health care professional doing invasive medical surgery should not be held to the same standard as eating in a restaurant. Health care providers and HIV itself are unique. The law should recognize the distinction.

Under the Rehabilitation Act of 1973 a person could choose not to contract with the federal government or be involved with institutions receiving federal money and exempt themselves from compliance. Health care workers and professionals today either must take the state-mandated risk of HIV or quit their profession. If private professional judgment is used in a health care situation that fails to comport with a public health decree, health care workers and professionals risk being taken all the way to the Supreme Court of the United States over $185.00. The Respondent and those in support of her cause, appear to want HIV patients treated individually, the same as all other patients, while, at the same time, treating health care providers as fungible without individual rights of choice and self protection. The common law never required a person to rescue another at his or her own peril. The risk of HIV belongs to the professional health care worker. Courage, conscience, and calling should determine whether to take that risk, not the government.

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[30] *Arline*, 480 U.S. 288 n. 18.

CONCLUSION

Based in the foregoing, Amicus Curiae, Promina Northwest Health System, respectfully requests that this Court reverse the decision of the United States Court of Appeals for the First Circuit, and dismiss Respondent's claims.

Respectfully submitted,

Lionel J. Postic
Counsel of Record
Stan D. Babb
Roger N. Wiles
Postic & Babb, LLC
191 Roswell Street, Suite 100
Marietta, Georgia 30060
(770) 795-9003

Counsel for Amicus Curiae
Promina Northwest
Health System

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In The

Supreme Court of the United States

October Term, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF OF THE *AMICUS CURIAE* THE AMERICAN DENTAL ASSOCIATION IN SUPPORT OF PETITIONER RANDON BRAGDON, D.M.D.

Peter M. Sfikas, Esquire
Counsel of Record
Mark S. Rubin, Esquire
Jill A. Wolowitz, Esquire
AMERICAN DENTAL ASSOCIATION
211 East Chicago Avenue
Chicago, IL 60611
Phone: (312) 440-2500

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INTEREST OF THE AMICUS

The AMERICAN DENTAL ASSOCIATION (the "Association"), an Illinois not-for-profit corporation founded in 1859, is the leading dental association in the United States with over 140,000 member dentists representing approximately 75% of this nation's active licensed dentists.[1] The stated object of the Association, as set forth in its Constitution, is to "encourage the improvement of the health of the public and to promote the art and science of dentistry." The Association has a vital interest in matters which affect the oral health of the public, and a long record of educating dentists and the public about HIV/AIDS and the safety of the dental office.

This brief seeks to begin to clarify the application of what is, to many dentists and other health care providers, an ambiguous federal law, the Americans with Disabilities Act (the "Act"). We applaud this Court for agreeing to address two key questions pertaining to the Act's "disability" definition, so we can give appropriate guidance to our members, who can in turn use this information when treating the American public. We note at the outset that this brief does not in any way challenge or undermine long-standing Association policy concerning the safety of the dental office and/or the treatment of HIV-infected individuals;[2] nor does it challenge whether someone who exhibits symptoms of HIV, including AIDS, is "disabled."

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[1] No counsel for a party authored any part of this amicus curiae brief, and no person or entity other than the amicus curiae made a monetary contribution to the preparation or submission of this brief. (Rule 37.6 of the Supreme Court of the United States.)

[2] As set forth in our amicus curiae brief below, the Association stands by its self-explanatory, cornerstone policies that (1) HIV-individuals should be treated with compassion and dignity, (2) there is little risk of

All parties have consented to the filing of this Brief, as reflected in the consent letters separately submitted to this Court. Pursuant to the Court's rules, the Brief brings to the attention of the Court relevant matter, from the perspective of America's leading dental association, not already brought to the Court's attention by the Petitioner. (Rule 37.1 of the Supreme Court of the United States.) Every effort has been made to avoid or minimize duplication with Petitioner's brief.

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transmission of HIV through dental treatment if recommended infection control procedures are routinely followed, (3) patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed, (4) such infection control procedures provide protection both for patients and dental personnel, and (5) a decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. American Dental Association's Policy Statement on AIDS, HIV Infection and the Practice of Dentistry (1988:457; 1991:591), Appendix at 273; ADA Principles of Ethics and Code of Professional Conduct, Section 1-A, Patient Selection, Advisory Opinion 1 (1988), Appendix at 276. In addition, after the filing of our brief below, the Association established policies Efficacy of Universal Precautions and Policy Statement on HIV/AIDS as an Infectious and Communicable Disease providing, inter alia, that (6) based on current scientific and epidemiological data, universal precautions continue to be an effective means of reducing blood contacts that can result in disease transmission, minimizing even further the already low risk of bloodborne disease transmission in the dental office, (7) given that data, patients with bloodborne diseases may be treated in the private dental office with no significant risk of disease transmission, provided appropriate infection control procedures are employed and (8) in Association communications on this issue, members be reminded that a patient's HIV/AIDS status is not a justification for refusal of treatment (1996: 734-735).

SUMMARY OF ARGUMENT

In the instant case, Respondent is an asymptomatic HIV-infected woman, whose claim of "disability" was based solely on her asserted inability to reproduce. To help clarify the legal obligations of health care providers in such situations, the Association asked this Court to address two aspects of the Americans with Disabilities Act's "disability" definition.

The Act defines "disability," in relevant part, as a "physical or mental impairment that substantially limits one or more of the major life activities" of the individual in question. 42 U.S.C. § 12102(2)(A) (1993). The Association believes that whether any particular plaintiff is disabled under the Act requires an individualized application of a not explicitly defined legal standard as to what constitutes both a major life activity and a substantial limitation of that activity.

The Association urges the Court to: (1) resolve a split in the federal appeals courts by holding "reproduction" is not a "major life activity" under the Act and (2) determine that the Act does not confer *per se* disability status on any condition, including HIV. On the first question, "reproduction" is unlike the activities listed in the regulations describing "major life activities," and outside of the protections offered by the Act. On the second question, it is of paramount importance that this Court exercise great care before adopting a *per se* rule, the implementation of which would be tantamount to a sea change of more than 20 years of case law decided since the passage of the Rehabilitation Act, in which federal courts have properly made individualized assessments of plaintiffs' claims of "handicap" or "disability."

While this brief addresses these two questions in the order accepted for review by this Court, we suggest that the Court treat them in reverse order. Following the agreed course set by every circuit court that has addressed this issue, we believe the Court should first determine that whether any condition or disease constitutes a "disability" under the Act must be assessed on a case-by-case basis. This would mean there is no *per se* rule for HIV/AIDS – a perfectly reasonable outcome given the plain language of the Act, especially in light of treatments for HIV-disease that have recently been developed. Only then is there need to address the second question, on which we urge the Court to hold that "reproduction" is not a "major life activity."

Because the Association urges this Court to resolve this case by ruling in Dr. Bragdon's favor on either or both of the two issues pertaining to the Act's "disability" definition, we do not reach the third question presented for the Court's review.

ARGUMENT

This brief addresses the first two questions accepted for review by this Court pertaining to the Americans with Disabilities Act's definition of "disability." However, we suggest that the Court treat them in reverse order. The starting point should be one on which the circuit courts of appeal agree: the plain language of the Act militates against finding conditions to be *per se* disabilities and instead compels a case-by-case determination of whether a given individual is disabled. Ennis v. National Ass'n of Business and Educ. Radio, Inc., 53 F.3d 55, 59-60 (4th Cir. 1995)(HIV-disease not a *per se* disability). Accord, Abbott v. Bragdon, 107 F.3d 934, 941 (1st Cir. 1997) and Runnebaum v. Nationsbank of Maryland, N.A., 123 F.3d

156, 166 (4th Cir. 1997) (employee with HIV-disease not disabled), citing, Homeyer v. Stanley Tulchin Assocs., Inc., 91 F.3d. 959, 962 (7th Cir.1996) and Katz v. City Metal Co., 87 F. 3d 26, 32 (1st Cir.1996) for the proposition that "a determination of disability must be made on an individualized, case-by-case basis."

Rejecting a *per se* disability rule for HIV/AIDS is a perfectly reasonable outcome, especially given the plain language of the statute and in light of treatments for HIV-disease that have recently been developed. Moreover, only after rejecting a *per se* rule is there need to address the second question, on which we urge the Court to hold that "reproduction" is not a "major life activity" under the Act.

While we suggest that the Court consider the first two questions presented for review in reverse order, we take them up below in the order accepted by the Court for review.

I. This Court Should Resolve The Split In The Circuits And Determine That "Reproduction" Is Not A "Major Life Activity" Under The Americans With Disabilities Act

Some persons with asymptomatic HIV-disease, such as Respondent Ms. Abbott, have claimed "disability" status under the Act based on their position that their ability to reproduce is substantially limited by their HIV infection.[3] The Association urges this Court to hold that "reproduction" is not a "major life activity" under the Act. Had Congress wanted the Act to require health care providers to treat persons with asymptomatic HIV-disease

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[3] Respondent's position is based on her "decision" not to reproduce (Abbott, 107 F.3d. at 942), as opposed to her physical ability to do so.

when their sole claim of actual disability is based on an asserted inability to reproduce, it could have expressly done so.

The plain language of the Act does not define what constitutes a "major life activity." The applicable regulations state that "major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 36.104(2) (1995). While the use of the words "such as" indicates that this list is illustrative rather than exhaustive, reproduction is unlike the specifically enumerated items on the list.

At least two federal appeals courts have rejected the argument that reproduction is a "major life activity." The court in Zatarain v. WDSU-Television, Inc., 881 F.Supp. 240, 243 (E.D.La. 1995), aff'd, per curium, 79 F.3d 1143 (5th Cir. 1996) reasoned that reproduction is not an activity engaged in with the same degree of frequency as the illustrative list of activities in the regulations and therefore treating reproduction as a major life activity under the Act would be a conscious expansion of the law beyond the province of the court. As set forth in the district court opinion:

> "Reproduction is not an activity engaged in with the same degree of frequency as the listed activities... A person is required to walk, see, learn, speak, breath [sic], and work throughout the day, day in and day out. However, a person is not called upon to reproduce throughout the day, every day. This court cannot reasonably infer that reproduction is a `major life activity' based on an analysis of the illustrative list of activities in the regulation. Treating reproduction as a major life activity under the ADA would be a conscious expansion of the law, which is beyond the province of this Court."

Id. at 243. The court in Krauel v. Iowa Methodist Medical Center, 95 F.3d 674, 677 (8th Cir. 1996) likewise held that reproduction is not a "major life activity," agreeing with the Zatarain position that to treat reproduction as a major life activity under the ADA would be inconsistent with the illustrative list of activities in the regulations and a considerable stretch of federal law.

By concluding that reproduction is a "major life activity" under the Act, the court in Abbott, 107 F.3d at 941, is in direct conflict with the above mentioned federal appeals court decisions. The Abbott court believed that reproduction "fits comfortably" within the sweep of the non-exclusive list of functions in the regulations. Id. at 940. However, the circuit split reflects that there is certainly no comfortable fit. Further, the Abbott court's disagreement with Krauel and Zatarain is questionable. True, neither lack of frequency nor lack of universality diminishes the importance of conceiving, childbearing and raising a family. But reproduction is simply not engaged in with the same frequency or universality as the listed functions. Further, while not each and every one of the activities enumerated in the regulations is engaged in by 100% of the population (Id. at 941), their inclusion in the list of "major life activities" is not a basis to expand the list by judicial fiat.

Other cases holding that reproduction is a "major life activity" are also unpersuasive. For example, the court in Pacourek v. Inland Steel Co., Inc., 916 F. Supp. 797, 804 (N.D.Ill. 1996) held that reproduction is a "major life

activity" because, inter alia, "[m]any, if not most, people would consider having a child to be one of life's most significant moments and greatest achievements, and the inability to do so, one of life's greatest disappointments" (emphasis added). However, the items on the regulatory list of "major life activities" are necessary parts of living for virtually everyone, not life "achievements." Taken to its illogical extreme, does Pacourek suggest that all Americans without children are disabled? What about those who cannot have them biologically but nevertheless are able to adopt? And what about people who simply do not accomplish other possible achievements that they might dream about? Are they disabled, too?[4]

Failing to find support in the statute or the regulations for the proposition that reproduction is a "major life activity" under the Act, some courts have examined legislative history. E.g., Abbott, 107 F.3d at 940. However, this Court has counseled that legislative history is often "highly unreliable" and "hazardous at best." Board of Educ. v. Mergens, 496 U.S. 226, 242 (1990). Indeed, this Court has refused to follow legislative history where it "is in no way anchored in the text of the statute." Shannon v. U.S., 512 U.S. 573, 583 (1994). See also, Wisconsin Public Intervenor v. Mortier, 501 U.S. 597, 617 (1991) (Scalia J.,

[4] Another of the cases relied on by the trial court reached a decision on an admittedly "thin" record. Doe v. Kohn Nast & Graf, P.C., 862 F.Supp. 1310, 1318-20 (E.D.Pa. 1994). Interestingly, the Doe court observed that the definition of "disability" for purposes of the Act is different than the one a lay person might give to the word; the Pacourek court might have been more mindful of this distinction when including "achievements" within the construct of "major life activities."

concurring) (legislative history is "unreliable...as a genuine indicator of congressional intent").

For the reasons set forth above, the Association urges this Court to determine that "reproduction" is not a "major life activity" under the Americans With Disabilities Act. "Reproduction" is unlike the activities listed in the regulations describing "major life activities." Thus, one whose only contention is that she "decided" not to have children is outside of the protections offered by the Act.

II. This Court Should Determine That The Americans With Disabilities Act Does Not Allow For Disability *Per se* Treatment Of Any Condition, Including HIV Disease

A. The Act Requires An Individualized Assessment of "Disability" for All Conditions

It appears that this case is the first the Court will hear on whether any particular condition, including HIV disease, constitutes a "disability" under the Americans with Disabilities Act. Especially in this context, the Association urges the Court not to single out any condition for *per se* disability treatment. Doing so would arguably represent a sea change in more than 20 years of case law since the passage of the substantially similar definition contained in the Rehabilitation Act.[5]

[5] The definition of "disability" in the ADA mirrors that of the term "handicap" in the Rehabilitation Act of 1973, 29 U.S.C. 701-96. The two terms have been interpreted identically. Pacourek, 916 F.Supp. 797, 801 (N.D.Ill. 1996). The courts look to case law interpreting both statutes when analyzing plaintiff's evidence of "disability." See, Nedder v. Rivier College, 944 F.Supp. 111, 115 n. 5. (D.N.H. 1996). As set forth more fully below, courts applying the Rehabilitation Act definition have routinely engaged in individualized determinations

The Association urges this Court to embrace the general approach agreed to by other circuit courts of appeal outside of the HIV/AIDS arena, requiring that "a determination of disability must be made on an individualized, case-by-case basis." Homeyer v. Stanley Tulchin Assocs., Inc., 91 F.3d. 959, 962 (7th Cir.1996); Katz v. City Metal Co., 87 F. 3d 26, 32 (1st Cir.1996). The Fourth Circuit has taken the lead in applying this approach in the context of HIV/AIDS (Ennis, 53 F.3d at 59-60) (plain language of the Act militates against finding HIV-disease to be a *per se* disability), recently holding that an asymptomatic HIV-infected employee was not disabled under the Act. Runnebaum, 123 F.3d at 166. On its face, the First Circuit took a similar approach in the instant case, rejecting a *per se* standard and instead exploring whether Respondent could prove that she satisfied the Act's disability definition. Abbott, 107 F.3d at 939.

The Association urges this Court to reject calls for a *per se* disability rule for any condition. Some decisions, like the First Circuit's in the instant case, come dangerously close to the adoption of such a standard.[6] Had Congress expressly

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regarding "handicap," including this Court in its landmark decision School Board of Nassau County, Florida v. Arline 480 U.S. 273 (1987), regarding another infectious disease, tuberculosis.

[6] In amending its original decision, the First Circuit highlighted that "Congress deemed HIV-infected individuals to be disabled under the ADA," quoting from the Act's legislative history that reflected "[p]ersons infected with the Human Immunodeficiency Virus are considered to have an impairment that substantially limits a major life activity, and thus are considered disabled under the first test of the definition...[and] a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." Abbott, 107 F.3d at 942-43. According to the Court,

sought to single HIV/AIDS out for special consideration, that would be one thing. But Congress did not. Rather, in framing the Americans with Disabilities Act, Congress relied upon a definition borrowed from the Rehabilitation Act, passed long before the advent of the AIDS epidemic.[7] Courts applying the definitions have routinely inquired into the facts in the record regarding a plaintiff's alleged disability, rather than carving out *per se* disability status for any condition. See, e.g., Forrisi v. Bowen, 794 F.2d 931, 933 (4th Cir. 1986); Byrne v. Board of Education, 979 F.2d 560, 564 (7th Cir. 1992).

Like the Rehabilitation Act before it, the Americans with Disabilities Act's statutory definition does not enumerate a list of disabilities, but instead characterizes "disability," in relevant part, as a "physical or mental impairment that substantially limits one or more of the major life activities" of the individual in question. 42 U.S.C. § 12102(2)(A). Accordingly, whether any particular plaintiff is disabled under the Act requires an individualized application of a not explicitly defined legal standard as to what constitutes both a major life activity and a substantial limitation of that activity. Indeed, the plain language of the Act militates against finding HIV disease to be a disability *per se* and compels a case-by-case determination of whether a given individual is disabled by HIV/AIDS. Ennis, 53 F.3d at 59-60. As set forth above, the courts of appeals considering this issue agree that findings of disability must be made on a case-by-case basis. Supra at pp.4 and 5.

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the "legislative history thus independently bolsters our conviction that Ms. Abbott is disabled under the ADA." Id. In point of fact, however, this added language risks tilting all other courts towards a *per se* rule for HIV.

[7] H.R. Rep. No. 485, Part 2, 101st Cong., 2nd Sess., 50 (1990).

Adopting a *per se* disability rule could allow for end runs around the Act's clear requirement of individualized assessments. It also risks eviscerating key elements of the Act's "disability" definition, such as whether a particular plaintiff with a given impairment is substantially limited in a major life activity . For example, some courts have held that cancer is a disability, Mark v. The Burke Rehabilitation Hospital, 1997 WL 189124 (S.D.N.Y. 1997); some courts have held it is not. Ellison v. Software Spectrum, Inc., 85 F.3d 187, 191 (5th Cir. 1996). Appropriately, courts on both sides have examined the facts of a particular case and eschewed the application of a *per se* rule.

The adoption of a *per se* rule could also risk the judiciary riding roughshod over matters that are best handled by triers of fact. Moreover, numerous decisions under both the Americans with Disabilities and Rehabilitation Acts have denied summary judgment and sent the issue of disability to the jury, often because the record did not resolve all issues of material fact as to whether the claimed impairment substantially limited an established major life activity. See, e.g., Hendry v. GTE No., Inc., 896 F.Supp. 816, 824-825 (N.D.Ind. 1995) (intermittent migraine headaches); Smith v. Kitterman, Inc., 897 F.Supp. 423, 427-28 (W.D.Mo. 1995) (carpal tunnel syndrome); Braverman v. Penobscot Shoe Co., 859 F.Supp. 596, 603 (D.Me. 1994) (cancer); Pridemore v. Legal Aid Society, 625 F.Supp. 1171, 1176 (S.D.Ohio 1985) (mild cerebral palsy, mental illness).

The Association is mindful that the rejection of a *per se* disability standard could lead to what may be viewed as harsh results, but the solution here would be a legislative, not a judicial, one. True, lower courts are limiting the "disability" definition in ways that many might not agree with, and with respect to conditions that many might

otherwise presume to be *per se* disabling. But a proper reading of the Act calls for an individualized determination of "disability" based on the record in a given case. For example, in Ellison, supra at p.12, the Fifth Circuit affirmed a grant of summary judgment against a woman with breast cancer, holding that she was not disabled because, inter alia, the record did not create a material issue of fact regarding whether her cancer and treatment "substantially limited" her major life activity of working – notwithstanding the plaintiff's testimony that while "the radiation treatment made her nauseous and tired and she suffered an allergic reaction to the radiation which caused painful swelling and inflammation, the treatment did not effect her ability to do her job and she...was back to normal in three or four months." Id. at 191. Likewise, in Still v. Freeport-McMoran, Inc., 120 F.3d 50, 52 (5th Cir. 1997), the Fifth Circuit found that blindness in one eye did not constitute disability, in part because plaintiff's "contention is without record support," where plaintiff offered "no evidence that he [was] unable to engage in any usual activity because of his partial blindness." These cases understand that the Act requires an individualized determination of "disability," and thus avoid the application of a *per se* rule for any condition. Congress can enact legislation to the contrary if it sees fit.

The Association urges this Court to track its approach in its seminal case School Board of Nassau County v. Arline, 480 U.S. 273 (1987), in which the Court considered whether an individual with tuberculosis was "handicapped" as defined in the Rehabilitation Act. That act's definition of "handicap" is the precursor to the Americans with Disabilities Act's "disability," 29 U.S.C. § 706(8)(B) (1993), and also "contemplate[s] individualized assessments of whether a person qualifies as an 'individual with a disability.'" Torcasio v. Murray, 57 F.3d 1340, 1353 n.15 (4th Cir. 1995). The Arline Court specifically reserved the question

of whether "a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act." Arline, 480 U.S. at 282, fn. 7. However, in determining whether one or more of plaintiff's major life activities were substantially limited by her tuberculosis, the Court looked to the fact that the she required hospitalization. Id. at 281. As set forth above, federal appeals courts since Arline have concluded that the question of who is a handicapped person under the Rehabilitation Act is best suited to a case-by-case determination. Supra at p.11. The same approach should continue to be carried over to cases now arising under the Americans with Disabilities Act.

B. Whether A Particular Plaintiff With HIV Has A "Disability" Requires An Individualized Determination

As noted above, the Fourth Circuit recently determined that an asypmtomatic HIV-infected individual was not disabled. In Runnebaum, 123 F.3d 156 (4th Cir. 1997), the Court properly undertook an individualized assessment of the plaintiff's alleged disability. Responding to amici's argument that Runnebaum's ability to procreate and engage in intimate sexual relations were substantially limited by his HIV-infection, the court determined that "asymptomatic HIV does not substantially limit procreation or intimate sexual relations for purposes of the ADA." Id. at 172. The court went on to specifically find "the record makes clear that Runnebaum's ability to engage in intimate sexual relations was not substantially limited by his HIV infection." Id. (emphasis added). See also, Cortes v. McDonald's Corp., et. al., 955 F.Supp. 541, 546 (E.D.N.C. 1996), holding that an asymptomatic HIV-infected employee of McDonald's was not disabled, in part because "according to

the record before the court, the plaintiff has failed to establish that he experienced any limitation at work, let alone a substantial limitation of a major life function."[8]

The Association urges the Court to reject the application of a disability *per se* rule to any condition, including HIV. Applying a blanket *per se* rule solely for diseases *de jour* can be confusing to the point that those charged with compliance, and the public in general, might genuinely loose confidence in the law, the lawmakers, and the courts that interpret the law. Laws must be consistently and fairly applied to instill public confidence, and compliance with the Act is likely to be optimized if it is applied consistently with respect to all diseases and conditions. Indeed, one of the Act's express purposes is "to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities." 42 U.S.C. § 1201(b)(2)(1993) (emphasis added).[9] The correct approach

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[8] In the instant case, the briefs below reflect the importance of looking to the record to determine whether a particular plaintiff has a "disability" under the Act, even in the case of asymptomatic HIV-infection. As set forth in our *amicus curiae* brief in the First Circuit, Respondent's contradictory deposition testimony could lead reasonable people to disagree as to whether her ability to reproduce was "substantially limited" by her asymptomatic HIV-infection. Of note is that the Department of Justice also relied on Respondent's deposition testimony, albeit to different ends, to support its position that she did have a "disability." In so doing, the Department of Justice arguably recognized that a disability *per se* approach is inconsistent with the plain language and intent of the Act.

[9] The Association urges that the Court consider going even a step further, by providing guidance to courts adopting rules that approximate *per se* standards. To emphasize that a determination of "disability" under the Act requires an individualized assessment, the Court might wish to level a slippery slope that at least one court, backing only slightly away from a *per se* rule, recently adopted. In

is to treat all conditions as subject to a case-by-case assessment of disability. The statute should not be read to accord *per se* disability treatment to HIV/AIDS alone, while subjecting all other diseases, such as cancer and blindness, to individualized assessments.

This Court should send a clear message that there are no "special" disabilities, and that all diseases and conditions will be judged by the same "disability" definition that was time tested long before the advent of HIV.[10] Doing so is necessary to assure that the law, as written, keeps up with scientific developments. Consider, for example, the advent of protease inhibitors and their miraculous impact on the lives of persons with HIV-disease. By the nature of this

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Hernandez v. Prudential Insurance Company of America, 977 F.Supp. 1160, 1165 (M.D.Fla. 1997), the court found that a plaintiff with asymptomatic HIV was disabled, based in part on its belief that his need for continued medical care demonstrated that he could not care for himself. This ruling begins the slippery slope because persons with many conditions need to visit their doctors, but that factor alone certainly does not mean they have a disability. The Hernandez court further relied on interpretive guidance indicating that impairments "such as HIV infection, are inherently substantially limiting." Id., citing 29 C.F.R. § 1630.2(j). Congress could have enacted similar language into law, but declined to do so, thus avoiding the slippery slope of rules approximating *per se* standards.

[10] The Association is mindful that some cases decided under the Rehabilitation Act could be viewed as approximating a *per se* standard for HIV-disease. It is not always clear that those cases involve asymptomatic HIV. Also, in some of the cases, the defense did not challenge whether HIV was a handicap. In others, the court presumed, with little or no analysis, that HIV disease constituted a handicap. None of these cases articulate a reasoned basis for abandoning the individualized inquiry required by the Rehabilitation Act, which is seemingly applied in all other cases arising under that Act not involving HIV.

scientific development, and the ability to reduce HIV RNA to undetectable levels in many cases, many persons once living with a death sentence may now have hope.[11] The First Circuit's opinion is predicated, in part, on the notion that Ms. Abbott could not reproduce; the court reached that determination based on a broad definition of reproduction, including that Ms. Abbott would not be alive long enough to mother a child.[12] The First Circuit purposefully limited its opinion to the facts of the case, recognizing that scientific developments might change how it resolved future cases.[13] The question must be asked: with the benefits of protease inhibitors, would a similarly situated woman prevail in the First Circuit today? The application of a *per se* rule would not allow this or other important questions to be asked, let alone answered. This Court should reject the application of a *per se* disability standard for any disability,

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[11] See, e.g., Carpenter, et al., Antiretrovial Therapy for HIV Infection in 1997, Journal of the American Medical Association, Vol. 277, No. 24 at 1962-69 (June 25, 1997)(describing scientific rationale for earlier initiation of more aggressive therapy and careful selection of initial drug regimen for optimal long-term clinical benefit); Douglas D. Richman, HIV Therapeutics, Science, Vol. 272 at 1886-87 (June 28, 1996); and Joan Stephenson, New Anti-HIV Drugs and Treatment Strategies Buoy AIDS Researchers, Journal of the American Medical Association, Vol. 275, No. 8 at 579 (February 28, 1996).

[12] Abbott, 107 F.3d at 939-41.

[13] Id. at 948. While the First Circuit left the door open for consideration of different facts, including those based on scientific developments, its decision, including by its construction of the Act's legislative history, still comes dangerously close to the application of a disability *per se* rule for HIV-disease.

including HIV, if only to establish that the law can adjust to such developments.[14]

CONCLUSION

The American Dental Association appreciates the opportunity to bring to this Court's attention issues pertaining to the Americans with Disabilities Act that are of paramount importance, in order to provide clear guidance to health care practitioners about their obligations to treat individuals with asymptomatic HIV-disease, particularly where those individuals claim "disability" status solely by virtue of an asserted inability to reproduce. We urge the Court to: (1) resolve the split in the circuit courts by holding "reproduction" is not a "major life activity" under the Act and (2) determine that the Act does not confer *per se* disability status on any condition, including HIV. The Court's resolution of these issues will, we trust, begin to clarify the determination of what is a disability under the Act.

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[14] In anticipation of briefs by others on the question this Court reserved in Arline, we urge the Court to consider that it would be difficult, if not impossible, to hold contagiousness alone can confer disability status by singling out HIV as a *per se* disability. If HIV-disease is a *per se* disability, why not hepatitis B, hepatitis C and tuberculosis? Beyond infection diseases, what of chronic conditions such as arthritis, multiple sclerosis and lupus? The fact that one's body cannot ameliorate the condition, or that the infection can be transmitted to others, has not previously persuaded this Court, or the lower courts, to abandon the statutory requirement for an individualized inquiry into whether a person's impairment substantially limits one or more major life activities.

Respectfully Submitted,

Peter M. Sfikas, Esq.
Counsel of Record
Mark S. Rubin, Esq.
Jill A. Wolowitz, Esq.
AMERICAN DENTAL ASSOCIATION
211 East Chicago Avenue
Chicago, IL 60611

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,
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SIDNEY ABBOTT, *et al.*,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF *AMICUS CURIAE* OF THE EQUAL EMPLOYMENT ADVISORY COUNCIL IN SUPPORT OF REVERSAL

ANN ELIZABETH REESMAN *
McGUINESS & WILLIAMS
Suite 1200
1015 15th Street, N.W.
Washington, D.C. 20005
(202) 789-8600
Attorneys for Amicus Curiae Equal Employment Advisory Council

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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BRIEF *AMICUS CURIAE* OF THE EQUAL EMPLOYMENT ADVISORY COUNCIL IN SUPPORT OF REVERSAL

The Equal Employment Advisory Council (EEAC) respectfully submits this brief as *amicus curiae*.[1] Letters of consent from all parties have been filed with the Clerk of the Court. The brief urges this Court to reverse the decision below, and thus supports the position of Petitioner Randon Bragdon, D.M.D., before this Court.

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[1] Counsel for EEAC authored the brief in its entirety. No person or entity, other than EEAC, its members, or its counsel, made a monetary contribution to the preparation or submission of the brief.

INTEREST OF THE *AMICUS CURIAE*

The Equal Employment Advisory Council (EEAC) is a nationwide association of employers organized in 1976 to promote sound approaches to the elimination of employment discrimination. Its members include over 300 of the nation's largest private sector corporations. EEAC's directors and officers include many of industry's leading experts in the field of equal employment opportunity. Their combined experience gives EEAC a unique depth of understanding of the practical, as well as legal, considerations relevant to the proper interpretation and application of equal employment policies and requirements. EEAC's members are firmly committed to the principles of nondiscrimination and equal employment opportunity.

All of EEAC's members are employers subject to Title I of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12111-12117 (Title I). All of EEAC's members own commercial facilities subject to Title III of the ADA, 42 U.S.C. §§ 12181-12189 (Title III), and many own, operate, lease, or lease to places of public accommodation, also subject to Title III.

Moreover, most of EEAC's members are federal contractors subject to Section 503 of the Rehabilitation Act of 1973, 29 U.S.C. § 793, which requires covered employers to take affirmative action to employ and advance in employment qualified individuals with disabilities. Also, some of EEAC's members are the recipients of federal financial assistance and therefore are subject to the nondiscrimination provisions of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794.

The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973 share a common definition of "disability," which establishes the parameters of the protected class under each statute. Both statutes define "disability" in terms of an impairment that "substantially limits a major life activity." Thus, EEAC members have a direct interest in the issues presented in this case; *i.e.*, whether "reproduction" is a major life activity under the ADA, so that a person who is "substantially limited" in "reproduction" is an "individual with a disability" protected by the ADA; and whether an impairment can be a disability *per se* and not subject to case-by-case analysis.

Because of its interest in the application of the nation's fair employment laws, EEAC has filed briefs as *amicus curiae* in numerous cases before this Court, the United States Courts of Appeals, and various state supreme courts. As part of this activity, EEAC participated as *amicus curiae* in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), and other cases in this Court construing the Rehabilitation Act of 1973. *E.g.*, *Alexander v. Choate*, 469 U.S. 287 (1985), *CONRAIL v. Darrone*, 465 U.S. 624 (1984); *University of Texas v. Camenisch*, 451 U.S. 390 (1981); *Southeastern Community College v. Davis*, 442 U.S. 397 (1979). In addition, EEAC has participated in several cases in the courts of appeals regarding the proper interpretation of the ADA's definition of "disability," *e.g.*, *Krauel v. Iowa Methodist Medical Center*, 95 F.3d 674 (8th Cir. 1996) (holding that "reproduction" is not a major life activity); and other issues. Thus, EEAC has an interest in, and a familiarity with, the issues and policy concerns involved in this case.

EEAC seeks to assist the Court by highlighting the impact its decision in this case may have beyond the immediate concerns of the parties to the case. Accordingly, this brief brings to the attention of the

Court relevant matter that has not already been brought to its attention by the parties. Because of its experience in these matters, EEAC is well situated to brief the Court on the relevant concerns of the business community and the significance of this case to employers.

STATEMENT OF THE CASE

Petitioner Randon Bragdon, D.M.D., is a dentist in Bangor, Maine. *Abbott v. Bragdon*, 107 F.3d 934, 937 (1st Cir. 1997). Respondent Sidney Abbott visited Dr. Bragdon's office on September 16, 1994 for a dental appointment. *Id.* She informed Dr. Bragdon's office that she had the HIV virus. *Id.* Dr. Bragdon examined Ms. Abbott, and found a cavity. *Id.* He then told her that he would not fill the cavity in his office, but would do so in a hospital. *Id.* While he would charge her his usual fee, Ms. Abbott would be responsible for hospital costs. *Id.* Ms. Abbott declincd, and filed a complaint against Dr. Bragdon under the Americans with Disabilities Act. *Id.* at 937-38.

The district court granted summary judgment for Ms. Abbott. *Abbott v. Bragdon*, 912 F. Supp. 580 (D. Me. 1995). The district court concluded that "reproduction" is a major life activity under the ADA, *id.* at 586, and that Ms. Abbott, who, although HIV-positive, was asymptomatic, was substantially limited in reproduction and therefore was an "individual with a disability" and a member of the protected class under the ADA. *Id.* at 586-87. Further, the lower court ruled, if Dr. Bragdon were to use the precautions recommended by the Center for Disease Control, treating an HIV-positive patient in his dental office would not pose a "direct threat" to the health and

safety of others. *Id.* at 591. Accordingly, the district court concluded, Dr. Bragdon had violated Title III of the ADA by refusing to treat Ms. Abbott in his office. *Id.* at 595. The U.S. Court of Appeals for the First Circuit affirmed, ruling, *inter alia*, that "HIV-positive status is a physical impairment that substantially limits a fecund woman's major life activity of reproduction." 107 F.3d at 942. This Court granted Dr. Bragdon's petition for a writ of certiorari.

SUMMARY OF ARGUMENT

The statutory definition of "disability" establishes the scope of the class protected under the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101 *et seq.* To make out a *prima facie* case under the ADA, a potential plaintiff must be able to show that he or she has a physical or mental impairment that substantially limits a major life activity, has a record of such an impairment, or is regarded as having such an impairment. 42 U.S.C. § 12102(2).

Accordingly, the meaning of the statutory term "major life activity" is of significant importance in determining the parameters of the protected class. Regulations developed under the Rehabilitation Act of 1973, from which the statutory definition was drawn, define "major life activity" as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." *E.g.*, 45 C.F.R. § 84.3(j)(2)(i). This list was adopted verbatim into regulations interpreting the ADA. 28 C.F.R. § 36.104 (Title III); 29 C.F.R. § 1630.2(i) (Title I).

"Reproduction" is incongruous with the listed activities. First, the listed activities share common char-

acteristics of frequency and duration that "reproduction" lacks. Second, the listed activities each describe a discrete function, while "reproduction" is an extremely broad term that describes the culmination of numerous different activities, an impairment of any one of which could preclude an individual from bringing forth offspring. Third, reproduction involves significant elements of personal choice that, as a practical matter, are not associated with the listed activities. For these reasons, "reproduction" is not properly viewed as a "major life activity conferring ADA coverage." *Krauel v. Iowa Methodist Medical Ctr.*, 95 F.3d 674 (8th Cir. 1996).

Many physical and mental impairments have the potential for severe and devastating consequences. For this reason, it may be tempting to declare such impairments as disabilities *per se* under the ADA. The statutory language, however, precludes such a result. As drafted, the statutory definition of "disability" requires an individualized assessment as to the degree of limitation an impairment imposes on an individual's major life activities. *Ennis v. National Ass'n of Business & Educ. Radio*, 53 F.3d 55 (4th Cir. 1995). Accordingly, the court below erred in treating Abbott's asymptomatic HIV-positive condition as a *per se* disability under the ADA.

ARGUMENT

I. "REPRODUCTION" DOES NOT CONSTITUTE A MAJOR LIFE ACTIVITY WITHIN THE MEANING OF THE AMERICANS WITH DISABILITIES ACT

A. The ADA's Definition of Disability, Which Establishes the Scope of the Protected Class, Addresses only Impairments of *Major* Life Activities

Title III of the Americans with Disabilities Act, 42 U.S.C. §§ 12101 *et seq.* (ADA) proscribes discrimination against an "individual . . . on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182. Similarly, Title I of the ADA prohibits discrimination in employment against a "qualified individual with a disability" because of a disability. 42 U.S.C. § 12112(a).

The threshold requirement for coverage under the ADA is that the plaintiff be an "individual with a disability" as that term is defined in the law.[2] For

[2] Both Titles also prohibit discrimination against an individual "because of the known disability of an indivdual with whom the individual or entity is known to have a relationship or association." 42 U.S.C. § 12182(b)(1)(D) (Title III). *See also* 42 U.S.C. § 12112(b)(4). Thus, although the ADA will protect nondisabled individuals in this instance, this protection still flows from the existence of a disability. Moreover, the ADA generally prohibits retaliation, coercion, intimidation, threats, or interference against any individual who opposes acts that are unlawful under the ADA, who participates in a proceeding under the ADA, who exercises rights granted by the ADA, or who aids or encourages another in doing so. 42 U.S.C. § 12203. Again, however, protection is linked inextricably to disability.

this reason, establishing the existence of a disability is the first element of the plaintiff's burden of proof in an ADA case in every circuit. *E.g., Soileau v. Guildford of Maine*, 105 F.3d 12, 14-15 (1st Cir. 1997); *Wernick v. FRB*, 91 F.3d 379, 383 (2d Cir. 1996); *Lawrence v. National Westminster Bank*, 98 F.3d 61, 68 (3d Cir. 1996); *Tyndall v. National Educ. Ctrs.*, 31 F.3d 209, 212 (4th Cir. 1994); *Rogers v. International Marine Terminals*, 87 F.3d 755, 758 (5th Cir. 1996); *McKay v. Toyota Motor Mfg.*, 110 F.3d 369, 371 (6th Cir. 1997); *DeLuca v. Winer Industries*, 53 F.3d 793, 797 (7th Cir. 1995); *Benson v. Northwest Airlines*, 62 F.3d 1108, 1112 (8th Cir. 1995); *Sanders v. Arneson Prods.*, 91 F.3d 1351, 1353 (9th Cir. 1996), *cert. denied*, 117 S. Ct. 1247 (1997); *White v. York Int'l Corp.*, 45 F.3d 357, 360 (10th Cir. 1995); *Gordon v. E.L. Hamm & Associates*, 100 F.3d 907, 910 (11th Cir. 1996), *cert. denied*, 66 U.S. L.W. 3416 (1997).

Thus, the statutory definition of "disability" establishes the scope of the protected class. The ADA defines "disability" as follows:

> The term "disability" means, with respect to an individual—
>
> (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
>
> (B) a record of such an impairment; or
>
> (C) being regarded as having such an impairment.

42 U.S.C. § 12102(2). Where the plaintiff in an ADA case is not an "individual with a disability," summary judgment is appropriate. *E.g., Wooten v. Farmland Foods*, 58 F.3d 382, 385 (8th Cir. 1995); *Bolton v. Scrivner, Inc.*, 36 F.3d 939, 944 (10th Cir. 1994), *cert. denied*, 513 U.S. 1152 (1995).

B. Reproduction Is Not Congruous With The List of Major Life Activities Commonly Identified in Connection With ADA Coverage

1. *An Identified List of "Major Life Activities," Rooted in the Rehabilitation Act, Is Associated with the ADA's Definition of Disability*

Neither the ADA nor its predecessor, the Rehabilitation Act of 1973,[3] explains any of the terms used in the definition, such as "physical or mental impairment," "substantially limits," or "major life activity." Both the U.S. Department of Justice, which has jurisdiction over Title III, and the Equal Employment Opportunity Commission, which has jurisdiction over Title I, have issued interpretive regulations that *inter alia*, offer definitions for significant statutory terms. 28 C.F.R. Part 34 (DOJ); 29 C.F.R. Part 1630 (EEOC). Each agency used as its source regulations interpreting Section 504 of the Rehabilitation Act. The Department of Justice relied on regulations of the Department of Health, Education and Welfare, 42 Fed. Reg. 22685 (1977) (codified at 45 C.F.R. Part 84). 56 Fed. Reg. 35543, 35548 (1991). The EEOC used regulations issued by the Department of Education at 34 C.F.R. Part 104. 29 C.F.R. § 1630.2 (h) (Appendix).

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[3] The ADA definition of "disability" mirrors the definition of "handicapped individual" in the Rehabilitation Act of 1973, 29 U.S.C. § 706, and the ADA's legislative history confirms the Rehabilitation Act as the source of the ADA definition. S. Rep. No. 101-116, at 21 (1989); H.R. Rep. No. 101-485, pt. 2, at 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 332; H.R. Rep. No. 101-485, pt. 3, at 27 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 450.

Both DOJ and the EEOC state that "the phrase 'major life activities' means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 36.104; 29 C.F.R. § 1630.2(i).[4] While the list is explicitly nonexclusive, preceded as it is by the phrase "such as," this does not make the list entirely open-ended. On the contrary, the Court must use some discretion in deciding what other functions properly may be added to the list. Every addition broadens the scope of the ADA's protected class, creating the potential for innumerable additional claims. Thus, additions to the list, if any, should be made only after careful consideration as to whether they truly belong there.

The court below added "reproduction" to the list. *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997). As the Eighth Circuit concluded in *Krauel v. Iowa Methodist Medical Center*, 95 F.3d 674 (8th Cir. 1996), however, "reproduction" is not properly viewed as a "major life activity" conferring ADA coverage. For

[4] Both agencies define "physical or mental" impairment as:

> (i) Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or
>
> (ii) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

28 C.F.R. § 36.104, 29 C.F.R. § 1630.2(h). According to both agencies, the definition was drawn from regulations interpreting the Rehabilitation Act. 56 Fed. Reg. 35543, 35548 (1991) (DOJ); 29 C.F.R. § 1630.2(h) (Appendix) (EEOC).

this reason, this Court should reverse the decision below.

2. *Unlike Reproduction, the Listed Activities Share Common Characteristics of Frequency and Duration*

The established list of major life activities has symmetry, in that the activities on the list are those which people do virtually on a daily basis for their entire lives. Living beings breathe constantly, and see and hear during waking hours. They walk, speak, care for themselves, and perform manual tasks many times a day, all their lives. Even those not actively engaged in study learn many small things each day.

"Reproduction" is distinguishable just on this basis:

> [F]inding "reproduction" to be a "major life activity" would be inconsistent with the illustrative list of major life activities provided in the ADA regulations. Reproduction is not an activity engaged in with the same degree of frequency as the listed activities of walking, seeing, speaking, breathing, learning, and working. A person is required to walk, see, learn, speak, breathe, and work throughout the day, day in and day out. However, a person is not called upon to reproduce throughout the day, every day. This Court cannot reasonably infer that reproduction is a "major life activity" based on an analysis of the illustrative list of activities in the regulation.

Zatarain v. WDSU-Television, Inc., 881 F. Supp. 240 (E.D. La. 1995), *aff'd without opinion*, 79 F.3d 1143 (5th Cir. 1996). *Accord Farmer v. National City Corp.*, No. C-2-04-966, 1996 U.S. Dist. LEXIS 20941, at *7-*8 (S.D. Ohio April 4, 1996).

Citing *Zatarain*, the Eighth Circuit likewise has concluded that "reproduction" does not belong in the list of "major life activities" under the ADA. *Krauel v. Iowa Methodist Medical Ctr.*, 95 F.3d 674 (8th Cir. 1996). Krauel sought coverage for her fertility treatments through her employer-provided health insurance coverage, and sued her employer under the ADA when the coverage was denied. Krauel claimed ADA protection based on her contention that she was substantially limited in "reproduction" and "caring for others" because her infertility prevented her from conceiving naturally. Concluding that Krauel was not a member of the protected class, the Eighth Circuit stated:

> While we recognize that this list is non-exclusive, we note that reproduction and caring for others are not among the examples of listed activities. Although Krauel is unable to conceive without medical intervention, she has the ability to care for herself, perform manual tasks, walk, see, hear, speak, breathe, learn, and work. . . We conclude, then, that to treat reproduction and caring for others as major life activities under the ADA would be inconsistent with the illustrative list of activities in the regulations, and a considerable stretch of federal law.

95 F.3d at 677.

The Eighth Circuit is correct. What the listed activities have in common—and "reproduction" does not—is that they are activities that everyone performs on a daily basis throughout their lives, and the inability to perform them makes day-to-day life more difficult. While individuals with disabilities routinely function effectively as productive members of society, there is no question that, on a daily basis, the inability

to see, or to hear, or to walk, or to speak makes it more difficult to do so.

"Reproduction" falls far short of this level. An individual who is unable to reproduce—but has no disability—goes about his or her day-to-day living unimpeded, able to get up, get dressed, eat breakfast, and go to school or to work without assistance.

3. *Unlike Reproduction, the Listed Activities Describe Discrete Functions*

Unlike "reproduction," the items listed as examples of major life activities describe particular, discernible functions. Walking, seeing, hearing, speaking, breathing, learning, and working all describe a single, recognizable act. Similarly, "caring for oneself" and "performing manual tasks" at most describe a category of similar functions with a commonality of purpose or execution.

Reproduction, on the other hand, is a broad term that encompasses a wide variety of functions. Reproduction incorporates the ability to have sexual intercourse, the ability to impregnate or to conceive, the ability to carry a child to term, and the ability to give birth to a viable infant. Indeed, the district court below also read "reproduction" to include "the process of raising and caring for offspring." *Bragdon*, 912 F. Supp. at 586.

Under an interpretation that "reproduction" in and of itself is a major life activity, a substantial limitation to any one of these activities would confer ADA coverage, regardless of whether or not any other functions were limited. Every prepubescent and every post-menopausal female, every impotent male, every person who has undergone a surgical procedure to

prevent conception, would become an "individual with a disability" who is a member of the protected class under the ADA.

This makes no sense, particularly since modern science has overcome many of the barriers to reproduction that previously existed. For those who have difficulty conceiving, there are fertility drugs. For those who are sterile, in vitro fertilization or surrogate paenthood may be viable options. Adoption has met the needs of many people whose goal is to raise a child.

4. *Reproduction Involves Significant Elements of Personal Choice Generally Absent From the Listed Activities*

As a practical matter, "reproduction" embodies an element of personal choice that customarily is not associated with the listed activities. Few of those who are able to care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, and work will simply elect not to do so. In contrast, people regularly make choices about each of the individual functions involved in reproduction, and for a variety of reasons. People choose, for example, not to have sexual intercourse with a member of the opposite sex, for moral reasons, as a lifestyle choice, or for a myriad of other reasons. People who do engage in sexual intercourse with a member of the opposite sex still may use birth control methods—including quasi-permanent surgical intervention, medication, and a variety of temporary devices—to prevent conception because they do not want to have a child. Perhaps they never want children; perhaps they do not choose to have a child now. Again, the reasons are legion—lifestyle choice, financial ability, the choice not to have

a child outside of wedlock, or the fear of passing a genetic defect or infectious disease. Similarly, women who become pregnant sometimes choose not to carry the child to term, and elect abortion instead, again for similar reasons. Finally, even a woman who carries a child to term may decide not to raise that child herself, but may delegate that duty to a relative or friend, or give the child up for foster care or adoption.

5. *Contrary Authority Is Not Well-Reasoned*

The cases decided in the Northern District of Illinois, *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393 (N.D. Ill. 1994), and *Erickson v. Board of Governors of State Colleges and Univs. for Northeastern Ill. Univ.*, 911 F. Supp. 316 (N.D. Ill. 1995), holding that "reproduction" is a major life activity under the ADA, are representative of the authority to the contrary and are wrongly decided for several reasons. First, they rely at least in part on the Seventh Circuit's decision in *McWright v. Alexander*, 982 F.2d 222 (7th Cir. 1992). In *McWright*, however, the employer did not dispute the plaintiff's contention that her infertility was a disability, perhaps because the infertility was a result of childhood polio which left the plaintiff with several other impairments as well.

Second, while recognizing that the issue of whether "reproduction" was a major life activity was not in dispute in *McWright*, the courts in *Pacourek* and *Erickson* nevertheless found persuasive dicta in *McWright* that "[t]he regulations define the protected class of handicapped individuals to include any person with a physiological disorder affecting the reproductive system." *McWright*, 982 F.2d at 395 (quoted in *Erickson*, 911 F. Supp. at 322, and cited in *Pacou-*

rek, 858 F. Supp. at 1404). Reliance on this language is misplaced as well. As a primary matter, it is incorrect. The regulations cited in *McWright*, 29 C.F.R. § 1613.702(b)(1), define *impairment* to include physiological disorders affecting the reproductive system. As noted above, not every impairment confers protected class status; only those that *substantially limit a major life activity*. Moreover, the fact that the regulations include disorders of the reproductive system as impairments does not lead inexorably to the conclusion that reproduction is a major life activity. "As the court in *Zatarain* observed, this argument is flawed because 'physical or mental impairment' and 'major life activities' are 'separate and distinct' components of the ADA's definition of disability." *Krauel*, 95 F.3d at 677 (quoting *Zatarain*, 881 F. Supp. at 243).

It is true that one congressional committee reporting out a version of the ADA commented that "a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." H.R. Rep. No. 101-485, pt. 2, at 52 (1990). No further explanation is offered, however. Nor does the Committee explain why, in the previous paragraph, it listed examples of "major life activities" without once mentioning either procreation or intimate sexual relationships. *Id.*

Likewise, the reference by the court below to conception and raising children as "basic civil rights" (quoting *Stanley v. Illinois*, 405 U.S. 645, 651 (1972)) misses the point. A plurality of the Fourth Circuit has observed that:

> [t]he constitutionally protected status of an activity . . . has little, if any, bearing on whether or not an activity is one of the major life activities contemplated by the ADA. Neither gathering in a group nor carrying a firearm are one of the major life activities under the ADA, though individuals have the constitutional right to peaceably assemble, *see* U.S. Const. Amend. I; and to "keep and bear Arms," U.S. Const. amend. II.

Runnebaum v. NationsBank of Maryland, N.A., 123 F.3d 156, 170 n.8 (4th Cir. 1997).

Expanding the existing list of "major life activities" to include "reproduction" would have an impact well beyond the scope of this case, and indeed, beyond Title III of the ADA. If "reproduction" were recognized as a "major life activity," then *any* physical or mental impairment that substantially limits any of the functions arguably part of "reproduction" would confer protected class status. Such a result would expand exponentially not only the number of individuals covered by the ADA, but also the obligation of employers to make "reasonable accommodation" for those "disabilities."

Accordingly, this Court should conclude that "reproduction" is not a major life activity under the ADA and reverse the decision below.

II. THERE ARE NO *PER SE* DISABILITIES WITHIN THE MEANING OF THE AMERICANS WITH DISABILITIES ACT

The statutory definition of "disability," which circumscribes the protected class under the Americans with Disabilities Act, is a threshold provision that all potential plaintiffs must meet. Each alleged victim of disability-based discrimination must demonstrate,

at the outset, that he or she has "a physical or mental impairment that substantially limits a major life activity," has a "record" of an impairment that substantially limits a major life activity, or has been "regarded as" having an impairment that substantially limits a major life activity. No lesser proof will do.

The statute by its terms, therefore, precludes the possibility that *any* impairment, however severe, can be a disability *per se*.

> [T]he plain language of the provision requires that a finding of disability be made on an individual-[b]y-individual basis. The term "disability" is specifically defined, for each of subparts (A), (B), and (C), "with respect to the individual," and the individualized focus is reinforced by the requirement that the underlying impairment substantially limit a major life activity *of the individual*.
>
> * * * *
>
> Were we to hold that A.J. was disabled under the ADA, therefore, we would have to conclude that HIV-positive status is *per se* a disability. The plain language of the statute, which contemplates case-by-case determinations of whether a given impairment substantially limits a major life activity, whether an individual has a record of such a substantially limiting impairment, or whether an individual is being perceived as having such a substantially limiting impairment, simply would not permit this a [sic] conclusion.

Ennis v. National Ass'n of Business & Educ. Radio, 53 F.3d 55, 60 (4th Cir. 1995) (emphasis in original) (citations omitted).

To its definition of "physical or mental impairment" in its regulations interpreting Title III of the ADA, the Department of Justice added:

> (iii) The phrase physical or mental impairment includes, but is not limited to, such *contagious and noncontagious* diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, *HIV disease (whether symptomatic or asymptomatic), tuberculosis*, drug addiction, and alcoholism.

28 C.F.R. § 36.104 (emphasis added). The regulation itself is not problematic, since it merely identifies conditions that are "impairments," not necessarily "disabilities." The Department's explanation, however, goes well beyond this point, concluding that HIV is a disability *per se*:

> The examples of "physical or mental impairments in paragraph 1(iii) are the same as those contained in many section 504 regulations, except for the addition of the phrase "contagious and noncontagious" to describe the types of diseases and conditions included, and the addition of "HIV disease (symptomatic or asymptomatic)" and "tuberculosis" to the list of examples. These additions are based on the ADA committee reports, case law, and official legal opinions interpreting section 504. In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), a case involving an individual with tuberculosis, the Supreme Court held that people with contagious diseases are entitled to the protections afforded by section 504. Following the *Arline* decision, this Department's Office of Legal Coun-

> sel issued a legal opinion that concluded that symptomatic HIV disease is an impairment that substantially limits a major life activity; therefore it has been included in the definition of disability under this part. The opinion also concluded that asymptomatic HIV disease is an impairment that substantially limits a major life activity, either because of its actual effect on the individual with HIV disease, or because the reactions of other people to individuals with HIV disease cause such individuals to be treated as though they are disabled.

56 Fed. Reg. 35543, 35548 (July 26, 1991) (citation omitted).

In so doing, the Department seriously misconstrued this Court's opinion in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987). Contrary to the Department's interpretation, this Court in *Arline* did *not* hold that individuals with contagious diseases were automatically *covered* by Section 504. Instead, the Court ruled in *Arline* that an individual is not *excluded* from statutory protection merely because the individual has a contagious disease. "We conclude that the fact that a person with a record of a physical impairment is also contagious does not suffice to remove that person from coverage under § 504." *Arline*, 480 U.S. at 285-86. Indeed, the Court stated explicitly that the issue of whether contagiousness alone would confer coverage was *not* being addressed.

> This case does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act.

480 U.S. at 282 n.7.

In explanatory material accompanying its regulations interpreting Title I, the EEOC explains in detail the need for an individualized determination of whether or not an impairment substantially limits a major life activity:

> Determining whether a physical or mental impairment exists is only the first step in determining whether or not an individual is disabled. Many impairments do not impact an individual's life to the degree that they constitute disabling impairments. An impairment rises to the level of disability if the impairment substantially limits one or more of the individual's major life activities. Multiple impairments that combine to substantially limit one or more of an individual's major life activities also constitute a disability.
>
> The ADA and this part, like the Rehabilitation Act of 1973, do not attempt a "laundry list" of impairments that are "disabilities." The determination of whether an individual has a disability is not necessarily based on the name or diagnosis of the impairment the person has, but rather on the effect of that impairment on the life of the individual. Some impairments may be disabling for particular individuals but not for others, depending on the stage of the disease or disorder, the presence of other impairments that combine to make the impairment disabling or any number of other factors.

29 C.F.R. § 1630.2(j) (Appendix). Inexplicably, then, and without any explanation, the agency then states that "other impairments, however, such as HIV infection, are inherently substantially limiting." *Id.*

The agency's main point—that whether or not a person is an "individual with a disability" depends upon the effect of an impairment on that indivdual's major life activities—is more consistent with the statutory language.

This Court's decision in *Arline* exemplifies the case-by-case analysis that is appropriate under the Rehabilitation Act as well as the ADA. *Arline* involved a teacher who was terminated because her tuberculosis, which had been in remission for twenty years, recurred three times in two years, and the school board feared contagion. 480 U.S. at 276. As noted above, this Court's holding in *Arline* was that a person who meets the statutory definition of an individual with a disability is not disqualified from the protected class merely because the disability poses a threat of contagion.

As part of its reasoning in *Arline*, however, this Court carefully considered the statutory definition before determining that Arline indeed was a member of the protected class. The Court first determined that Arline had had a physical impairment under the regulatory definition, since according to medical testimony, Arline's tuberculosis was severe enough in 1957 to affect her respiratory system. Since the condition was "serious enough to require hospitalization" at the time, the Court concluded that Arline's major life activities had been limited at the time. For this reason, the Court ruled, Arline had a "record" of a disability that placed her within the protected class. 480 U.S. at 281.

The statutory definition of "disability" mandates an individualized inquiry whether a physical or mental impairment substantially limits the particular individual in one or more major life activities. To declare, by judicial fiat, that one impairment or another is *per se* a disability undermines this important concept. Accordingly, this Court should conclude that there are no "*per se*" disabilities under the ADA.

CONCLUSION

For the foregoing reasons, *amicus* Equal Employment Advisory Council respectfully submits that the decision below should be reversed.

Respectfully submitted,

ANN ELIZABETH REESMAN *
MCGUINESS & WILLIAMS
Suite 1200
1015 15th Street, N.W.
Washington, D.C. 20005
(202) 789-8600
Attorneys for Amicus Curiae Equal Employment Advisory Council

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* Counsel of Record

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF FOR AMICUS CURIAE THE ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION IN SUPPORT OF RESPONDENTS

ALTHEA GREGORY
5500 Friendship Blvd.
Chevy Chase, MD 20815
(301) 951-3602

LYNN E. CUNNINGHAM*
Associate Professor of
Clinical Law
The Jacob Burns Community
Legal Clinics
The George Washington
University Law School
2000 G Street, N.W.
Suite 200
Washington, D.C. 20052
(202) 994-7463

*Counsel of Record

Counsel for Amicus Curiae

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-156

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF FOR AMICUS CURIAE THE ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION IN SUPPORT OF RESPONDENTS

INTEREST OF THE AMICUS CURIAE

The Elizabeth Glaser Pediatric AIDS Foundation (the "Foundation") identifies, funds, and conducts research into the human immunodeficiency virus ("HIV") particularly as it affects the health of children.[1] The Foundation has a three-

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[1] Pursuant to Supreme Court Rule 37.6, amicus states that no counsel for a party authored this brief in whole or in part and no person, other than amicus or its counsel, made a monetary contribution to the preparation or submission of the brief. This brief is submitted with the consent of all of the parties, whose letters of consent have been lodged with the Clerk.

fold mission: to develop therapies preventing transmission of HIV from an infected mother to her newborn; to prolong and improve the lives of children with HIV; and to eliminate HIV in infected children. To date, the Foundation has raised nearly $60,000,000 in support of pediatric HIV and AIDS research. It has funded over two hundred research grants, several long-term clinical studies, and emergency assistance programs for pediatric AIDS patients and HIV-positive pregnant women in hospitals across the country, and it has played a primary role in educating the public about HIV and AIDS, including conducting national campaigns encouraging pregnant women to be tested for the virus.

The Foundation wishes to apprise the Court of the significance of this case for a group often ignored in the current debate over the reach of the Americans with Disabilities Act ("ADA")—the thousands of children who are infected with HIV, and those children not yet born who are at risk of contracting the disease from infected mothers. AIDS is the seventh-leading cause of death for children under four years of age in the United States. Nearly all children infected with the virus acquire it from their mothers *in utero* or during childbirth. As of 1997, between ten and twenty thousand children were estimated to be infected with HIV themselves. Over forty thousand children, many of them uninfected, had lost one or both of their parents to AIDS by that time.

The Foundation, and those whose interests it advocates, have a substantial interest in this case. As Congress recognized in enacting the ADA, fear of discrimination can deter people infected with HIV (including pregnant women) from seeking critical early testing, counseling, and treatment—*before* outward symptoms arise—that would in many cases prevent children from ever acquiring the disease. Moreover, when children do contract HIV, they, like their adult counterparts, face severe discrimination on the basis of that status. Thus, it is of vital importance to the lives of many of the Nation's children that the Court confirm Congress' intent that *all* individuals with HIV—regardless of visible symptoms or stage of life—be protected from invidious discrimination.

SUMMARY OF ARGUMENT

When it enacted the ADA, Congress specifically intended to protect all HIV-infected individuals from invidious discrimination, in part to ensure that the fear of such discrimination would not deter these people from seeking needed testing and treatment. This public health goal would be severely compromised if the Act were interpreted to protect only those who have manifested outward symptoms of the infection. Indeed, it is now even more imperative that individuals without visible symptoms of infection receive the protection Congress intended, for it is at that early stage of the disease that treatments are most effective.

Such protection is particularly important to the health and well-being of the Nation's children. Clinical studies have shown that treatment of an HIV-positive pregnant woman before major symptoms arise greatly reduces the likelihood that her child will contract the virus. This research showed a nearly two-thirds reduction in the transmission of the virus from mother to infant. In practice, three years after the research study concluded, transmission from mothers to children has been dramatically reduced in the United States as pregnant women have been offered counseling, testing, and treatment. This will save the lives of thousands of children. A decision legitimizing discrimination against HIV-positive individuals without visible symptoms would slow that progress considerably by deterring individuals from seeking needed testing and treatment and participating in critical research, all contrary to Congress' clear intent.

In addition, in enacting the ADA Congress specifically intended to protect all HIV-infected individuals from discrimination on the basis of that status, regardless of their particular stage of life. For example, Congress was concerned about, and intended to prohibit, invidious discrimination against children with HIV, which Congress recognized as a serious problem. Indeed, before enactment of the ADA, HIV-infected children received protection under earlier anti-discrimination laws even before their adult counterparts. It

would completely subvert Congress' intent to now legitimize discrimination against these children.

The language of the ADA and its implementing regulations establish that individuals with HIV, but without visible symptoms, are covered by the statute. As is true with all individuals infected with this fatal virus, whether showing external symptoms or not, major life activities of HIV-infected children—indeed, their very lives—are substantially limited as a result of their condition. Under the statutory language, HIV is a "physical impairment," and reproduction (necessarily including conception, pregnancy, delivery, and child-rearing) is a "major life activity" that is "substantially limited" by that impairment. This is so for *all* individuals with HIV. Congress intended to extend the ADA's protection to all those with physical impairments, like HIV, that are so severe that they will limit a major life activity as compared with the general population. Moreover, HIV is a fatal, incurable condition that significantly reduces one's life expectancy. Accordingly, HIV meets the statutory definition of a disability because it substantially limits *all* major life activities—indeed, life itself.

The Foundation therefore urges the Court to uphold the decision below and make clear that all persons with HIV, whether exhibiting visible symptoms or not, adults or children, are protected under the ADA. To hold otherwise would relegate infected children and adults who have not yet developed outward symptoms to a second-class status and permit discrimination precisely when medicine and public health most need it to be prevented. If the ADA is to achieve its ultimate purpose, it must ensure that all people who suffer from this stigmatizing fatal disease will not face invidious discrimination as a result of that disability.[2]

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[2] This brief focuses on the first two questions presented in the Court's grant of certiorari. The Foundation, however, also supports respondent's position on the third question presented: that there should be a presumption in favor of universal expert and professional standards when evaluating whether a patient presents a "direct threat" under the ADA. Such an interpretation is critically important in ensuring proper medical care for children and others infected with HIV, as studies have shown that many health care providers would refuse to treat HIV-infected individuals if given the choice. *See* Barbara Gerbert et al., *Primary Care Physicians and AIDS: Attitudinal and Structural Barriers*, 266 J. Am. Med. Ass'n 2837, 2841 (1991); Charles E. Lewis & Kathleen Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected With the Human Immunodeficiency Virus*, 156 W. J. Med. 36, 37 (1992).

ARGUMENT

I. THE ADA WAS SPECIFICALLY INTENDED TO PREVENT THE HARMS ARISING FROM INVIDIOUS DISCRIMINATION AGAINST *ALL* THOSE INFECTED WITH HIV

The purpose of the ADA was simple: "to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life." S. Rep. No. 116, 101st Cong., 1st Sess. 2 (1990). To accomplish this purpose, Congress prohibited discrimination against all individuals with physical impairments so severe that the individuals were, in Congress' view, likely to be the targets of invidious discrimination that would prevent them from being integrated into the mainstream of American life.

This goal will be thwarted if the ADA is construed to protect HIV-infected individuals only when they presently experience outward symptoms. Rather, in order to ensure that persons with HIV are incorporated into the mainstream of society and are not deterred from seeking vital testing and treatment, Congress specifically intended to prohibit invidious discrimination against *all* individuals infected with this fatal disease—whether outwardly manifesting symptoms or not, children or adults.

A. The Health of the Nation's Children Would be Threatened, Contrary to Congress' Clear Intent, if the ADA Were Held to Protect Only Those With Outward Symptoms

Congress recognized that the harm it sought to prohibit through the ADA—specifically including discrimination against HIV-infected individuals—has wide-ranging effects on both the person with the disability and society at large. In describing the nature and extent of the problem it sought to combat, Congress expressly noted that "discrimination against individuals with HIV infection is widespread and has serious repercussions for both the individual who experiences it and for the Nation's efforts to control the epidemic." *Id.* at 8. Both houses of Congress thus endorsed the conclusions of a presidential report that:

> "As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination * * * will undermine our efforts to contain the HIV epidemic and will leave HIV-infected individuals isolated and alone."

Id. at 8 (quoting *Report of Presidential Commission on the Human Immunodeficiency Virus Epidemic* 119 (1988)); H.R. Rep. No. 485, 101st Cong., 1st Sess., pt. 2 at 31 (1990).[3] In recognizing this fact, Congress simply echoed this Court's understanding that protection against disability discrimination "will assist local health officials by helping remove an important obstacle to preventing the spread of infectious diseases: the individual's reluctance to report his or her condition." *School Bd. of Nassau County* v. *Arline*, 480 U.S. 273, 286 n.15 (1987).

In light of Congress' intended purpose of containing the epidemic by removing the obstacles to testing and treatment caused by discrimination, it is essential that the protection of the ADA be afforded to individuals who have not yet begun to experience the outward symptoms of the disease. For it is at this stage that testing, treatment, and research are increasingly most effective. The scientific evidence is clear that to be most effective, monitoring and treatment for HIV must begin long before any visible symptoms arise.[4] Recent guidelines for adults and children emphasize the importance of early identification of HIV infection through testing. These guidelines make clear that early diagnosis *before* external symptoms develop, and regular monitoring thereafter, are important to determining when to begin antiretroviral therapy as well as treatments to prevent opportunistic infections.[5] To hold that the ADA applies only to a narrow

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[3] *See also* 135 Cong. Rec. S10789 (daily ed. Sept. 7, 1989) ("By barring discrimination based on HIV infection, we clear the path not only to voluntary AIDS testing and counseling—but also to appropriate medical treatment that benefits the individual patient.") (statement of Sen. Kennedy); *Justice Dept. Memo on the Application of Section 504 of the 1973 Rehabilitation Act to HIV-Infected Persons*, 641 Fair Empl. Prac. Cas. (BNA) at 405 (1988) (statement of Surgeon General C. Everett Koop, M.D. that, for counseling and testing to be most effective, "individuals must have confidence that they will be protected fully from HIV related discrimination").

[4] *See* Katherine Luzuriaga et al., *Combination Treatment with Zidovudine, Didanosine, and Nevirapine in Infants with Human Immunodeficiency Virus Type 1 Infection*, 336 New Eng. J. Med. 1343 (1997); Centers for Disease Control and Prevention, *1995 Revised Guidelines for Prophylaxis Against* Pneumocystis carinii *Pneumonia for Children Infected with or Perinatally Exposed to Human Immunodeficiency Virus*, 44 Morbidity & Mortality Wkly. Rep. 1, 5-6 (1995); David D. Ho, M.D., *Time to Hit HIV, Early and Hard*, 333 New Eng. J. Med. 450 (1995); American Academy of Pediatrics, Provisional Committee on Pediatric AIDS, *Perinatal Human Immunodeficiency Virus Testing*, 95 Pediatrics 303, 304 (1995).

[5] *See* Centers for Disease Control and Prevention, *1998 Guidelines for Treatment of Sexually Transmitted Diseases*, 47 Morbidity & Mortality Wkly. Rep. 11 (1998); Working Group on Antiretroviral Therapy and Medical Management of HIV Infected Children, *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection* 4 (1997) <http://www.hivatis.org/revpedgu.html>; Panel on Clinical Practices for Treatment of HIV Infection, *Guidelines for the Use of Antiretroviral Agents in HIV-*

category of infected individuals—those with visible symptoms—would be to withhold protection from discrimination precisely where it is increasingly needed most.[6]

Perhaps nowhere is Congress's goal of removing obstacles to early testing and treatment more important than in protecting the health of the Nation's children. An important study, completed in 1994, examined the effect of drug therapy on the transmission of HIV from pregnant mothers to their children. The study involved pregnant women with HIV who did not have AIDS and, according to the standards of the time, did not require antiretroviral therapy such as the drug zidovudine ("AZT") to maintain their own health. The study discovered that administering AZT to these pregnant women reduced transmission of HIV from pregnant mother to child by nearly two-thirds—from 23% to only 8%.[7] As a result of this research, the number of perinatally-acquired AIDS cases dropped by a staggering 43% between 1992 and 1996—perhaps the greatest preventive advance since the advent of the HIV epidemic. *See* Centers for Disease Control and Prevention, *Update: Perinatally Acquired HIV/AIDS—United States, 1997*, 46 Morbidity & Mortality Wkly. Rep. 1086,

Infected Adults and Adolescents 5 (1997) <http://www.hivatis.org/upguidaa.html.>; Charles C.J. Carpenter et al., *Antiretroviral Therapy for HIV Infection in 1997: Updated Recommendations of the International AIDS Society—USA Panel*, 277 J. Am. Med. Ass'n 1962 (1997).

[6] *See* 135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) (in light of evidence that AZT is helpful for "those that have tested positive but do not have the disease," "if you are going to encourage individuals to come forward for counseling and testing and crucial medical care—if you are going to get them to go out and pursue voluntary testing, we must not limit their protection under this act") (statement of Sen. Kennedy).

[7] *See* Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 New Eng. J. Med. 1173, 1178 (1994); Rhonda S. Sperling et al., *Maternal Viral Load, Zidovudine Treatment, and the Risk of Transmission of Human Immunodeficiency Virus Type 1*, 335 New Eng. J. Med. 1621, 1622-23 (1996).

1088 (1997). The dramatic decline in perinatally-acquired AIDS is believed to be indicative of the effectiveness of AZT in reducing perinatal HIV transmission. *Id.* at 1089. Current guidelines recommend that all pregnant women with HIV be offered AZT, and advised about its utility in reducing transmission, early in the pregnancy.[8]

Perinatal transmission of HIV, however, can only be prevented if pregnant women are willing to be tested and treated. Yet public health officials and others have recognized (as did Congress in enacting the ADA) that pregnant women may fail to be tested for HIV due to fear of discrimination. *See* Committee on Prenatal and Newborn Screening for HIV Infection, Institute of Medicine, *HIV Screening of Pregnant Women and Newborns*, App. A, at 124 (1991) (conference summary noting that to avoid discrimination, "some pregnant women refuse to be tested"); Mireya Navarro, *Testing Newborns for AIDS Virus Raises Issue of Mothers' Privacy*, N.Y. Times, Aug. 8, 1993, at 1 ("[S]ome women refuse to take the [HIV] test even when reached by H.I.V. counselors, fearing that they would lose their children or suffer discrimination if the test indicated infection."). If pregnant women are less willing to come forward for fear of discrimination against themselves or their children, thousands of children will unnecessarily be infected with HIV and die.

In addition, fear of discrimination can also affect treatment once it has begun. The efficacy of current treatment regimens depends on medications being administered virtually around-the-clock.[9] If individuals are unwilling to take these

[8] Centers for Disease Control, *Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States*, 47 Morbidity & Mortality Wkly. Rep. 2, 2-14 (1998).

[9] Current treatment regimens are extremely complex, requiring individuals to take dozens of pills each day and at many different times during the day. Lawrence K. Altman, *Hope vs. Hype—A Special Report; With AIDS, Advance, More Disappointment*, N.Y. Times, Jan. 19, 1997, at 1.

medications in public settings, such as school or the workplace, due to fear of discrimination, their treatment will be compromised, which could in turn result in a resistant strain of the virus. *See, e.g.*, Joyce Cohen et al., *School-Related Issues Among HIV-Infected Children*, 100 Pediatrics e8 (July 1997) <http://www.pediatrics.org/cgi/content/full/100/1/38> (reporting case of child who hid in school bathroom to take his medications in order to hide HIV status from school nurse); Steven G. Deeks et al., *HIV-1 Protease Inhibitors: A Review for Clinicians*, 277 J. Am. Med. Ass'n 145 (1997) (indicating that failure to maintain a strict drug regimen can lead to drug-resistant strains of HIV).

Failure to protect people without visible symptoms of their HIV infection from discrimination will likewise have adverse effects on vital research into the causes and treatment of HIV and AIDS. Such research depends entirely on the participation of volunteers. *See, e.g.*, 45 C.F.R. §§ 46.111(a)(4), (5); 45 C.F.R. § 46.116(a)(8). Public health would thus be jeopardized if the law provides no protection from discrimination based on HIV status, as people would be less willing to come forward to participate in research.[10] As with the study of perinatal transmission noted above, much of the most important research today involves individuals without

[10] *See Hearings on AIDS Counseling, Testing, Confidentiality and Nondiscrimination Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 100th Cong., 1st Sess. 1 (1987) (lack of nondiscrimination provisions threatens "the Nation's ability to study and understand the [HIV] epidemic. What we know about the disease we know because people have volunteered to cooperate with research efforts. If misguided testing policies drive these people away, it will only prolong the epidemic.") (statement of Rep. Waxman); James Tobin, *The Neglected Victims: More Females Fall to Deadly Affliction: Lack of Studies on Women Slows Treatment*, Det. News, Dec. 28, 1997, at A1 (many women "are reluctant to join a research study for fear of revealing their infection to employers, friends, even family members").

visible symptoms—the very people who would lack protection if petitioner were to prevail here.[11]

At a time when the most effective HIV treatments, and the most important research, increasingly involve individuals *without* visible symptoms, it is essential that these people not be deterred from coming forward. Until now, pregnant women and others who suspected they might be infected could reasonably believe, based on Congress' clear intent and the virtually uniform case law in the area, that they would not face discrimination based on their HIV status. If the Court now decides that such discrimination is lawful until external symptoms appear, these individuals would be forced to choose between being tested for the presence of a virus that is invariably fatal, and the potential loss of housing, employment, day care, schooling, medical care, and other necessary services. As Congress itself concluded, the failure to protect HIV-positive individuals without visible symptoms from discrimination will deter them from ascertaining their own HIV-status, complying with suggested treatments, and participating in critical research. It would therefore be a legal irony, a medical anomaly, and a threat to public health—particularly that of the Nation's children—to hold that the ADA protects HIV-infected individuals only when their disease has manifested itself with outward symptoms.

B. Congress Recognized That Individuals Infected With HIV Face Invidious Discrimination Regardless of Their Stage of Life

Just as Congress' public health goals would be compromised if the ADA's protection were limited only to individuals with outward symptoms, so too its goal of incorporating all those with HIV into the mainstream of society would be thwarted if protection were limited, as petitioner suggests, only to "women of childbearing age." Pet. Br. 13. Congress

[11] *See Clinical Trials for Asymptomatic Persons, AIDS Education Global Information System* (1997) <http://www.aegis.com/aegis/trials/asymptomatic.htm> (listing clinical trials of therapies and vaccines for people with asymptomatic HIV infection).

was concerned about preventing invidious discrimination against *all* individuals infected with the virus, specifically including children.

All persons with HIV, whether exhibiting visible symptoms or not, children or adults, experience invidious discrimination on account of that physical impairment. Unfortunately, discrimination against HIV-infected children has been, and continues to be, a particular problem. For example, a family in Florida with infected children received death threats and their house was burned in an attempt to keep the children from attending school.[12] An infected child was sprayed with bleach after sneezing in her kindergarten classroom.[13] Day care centers and schools still turn away children who are HIV-positive.[14] And the late Elizabeth Glaser, co-founder of the Foundation, concealed the fact that her children were infected with the virus, for fear of discrimination against them in school, recreation, and daily life.[15]

The earliest cases involving discrimination against HIV-infected individuals were filed by children against their schools under the Rehabilitation Act of 1973, whose definition of disability was adopted in the ADA. In one of the first of these cases, a child with HIV was held to be disabled under the Rehabilitation Act. *See District 27 Community*

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[12] *See* Elizabeth Glaser & Laura Palmer, *In the Absence of Angels* 59-60 (1991) [hereinafter "Glaser & Palmer"].

[13] *See I Need a Friend: Kids Talk About Having the AIDS Virus* (National Cancer Institute, Pediatric Branch) (videotape on file with the Elizabeth Glaser Pediatric AIDS Foundation).

[14] *See Suits Say Child with HIV Denied Admission to Day Care Centers*, Disability Compliance Bulletin 11 (July 31, 1997); Jonathon Briggs, *Parents Find Support They Can Depend On*, Ariz. Republic, Sept. 8, 1996, at F10 (HIV-positive women and children face problems obtaining child care); Purvette A. Bryant, *Session Focuses on Women with HIV; Physicians and Social Workers Discussed Better Ideas and Ways to Help*, Orlando Sentinel, July 27, 1996, at C1 (women with HIV commonly face problems with housing, child care, transportation, and day care).

[15] *See* Glaser & Palmer, *supra* note 12, at 50-51, 53, 61-62.

School Bd. v. *Board of Educ.*, 502 N.Y.S.2d 325, 336 (N.Y. Sup. Ct. 1986). Congress specifically sought to continue this protection when it enacted the ADA. The Act's legislative history demonstrates that Congress was deeply concerned about discrimination against HIV-positive children, whether visibly symptomatic or not. The committee hearings and floor debates are replete with references to children afflicted with HIV, especially Ryan White, a child with HIV who was barred from school and whose crusade against discrimination brought him national attention and admiration before his death from AIDS.[16]

It would subvert Congress' intent if children infected with HIV—who were protected from discrimination under judicial interpretations of federal anti-discrimination laws long before their adult counterparts—now found themselves stripped of that protection. HIV is a serious, stigmatizing impairment regardless of one's symptomatic status or stage of life, and the protection of the ADA should extend equally to *all* individuals with that disability.

II. ALL PEOPLE INFECTED WITH HIV HAVE A DISABILITY UNDER THE ADA

Congress' intended goal of eliminating discrimination against all persons infected with HIV is readily apparent from the text of the ADA, its implementing regulations, and its legislative history.[17] In the ADA, Congress broadly prohib-

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[16] *See, e.g.*, 136 Cong. Rec. H2479 (daily ed. May 17, 1990) (statement of Rep. McCloskey); *id.* at H2480 (statement of Rep. McDermott); *id.* at H2481 (statement of Rep. Jontz); *id* at S7438 (daily ed. June 6, 1990) (statement of Sen. Harkin); *Hearings Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped on S. 933*, 101st Cong., 1st Sess. 102 (1989); *Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary on H.R. 2273*, 101st Cong., 1st Sess. 171 (1989).

[17] The legislative history of the ADA is unequivocal that members of Congress—both supporters and opponents of the Act—as well as the President understood and recognized that all individuals with HIV be protected. *See, e.g.*, H.R. Rep. No. 485, 101st Cong., 1st Sess., pt. 2 at 52 ("a person infected with the Human

ited discrimination against any person with a physical impairment that "substantially limits" one or more "major life activities." 42 U.S.C. § 12102(2). HIV, whether visibly symptomatic or not, is plainly a physical impairment that substantially limits major life activities. There is no dispute that HIV infection is, in every affected person, a physical impairment of the hemic and lymphatic systems. And, whether visibly symptomatic or not, HIV infection substantially limits not only the major life activity of reproduction, as the Court of Appeals found, but indeed *all* major life activities, because the virus substantially limits life itself.

A. HIV Infection is a Physical Impairment

HIV infection is plainly a "physical impairment" within the meaning of the statute, and petitioner does not argue otherwise. When HIV first enters the bloodstream, it immediately

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Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships"); S. Rep. No. 116, 101st Cong., 1st Sess. at 22 ("[A] person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability.'"); 135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) ("[W]e have pointed out very clearly, if you are asymptomatic and HIV-positive, you are protected; if you have full-blown AIDS, you are protected.") (statement of Sen. Kennedy); 136 Cong. Rec. S9696 (daily ed. July 13, 1990) (ADA covers "individuals who have any condition along the full spectrum of HIV infection") (statement of Sen. Kennedy); 136 Cong. Rec. H2422 (daily ed. May 17, 1990) ("With this bill * * * if it is adopted, every HIV carrier in the country immediately comes within the definition of a disabled person") (statement of Rep. Dannemeyer); 135 Cong. Rec. S10766 (daily ed. Sept. 7, 1989) ("those who are HIV positive * * * are covered") (statement of Senator Helms); 135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) ("I am talking about those who are HIV positive. You include them as handicapped * * *.") (statements of Sen. Helms); 136 Cong. Rec. S9527 (daily ed. Mar. 29, 1990) ("Our goal is to turn irrational fear into rational acts. * * * I call on Congress to get on with the job of passing a law—as embodied in the Americans with Disabilities Act—that prohibits discrimination against those with HIV and AIDS.") (statement of President Bush).

begins attacking and disabling white blood cells, which normally control infections in the body. The virus is never dormant. During the so-called "asymptomatic" period, the virus multiplies at a rate of a billion particles per day, and actively invades, infects, and kills the body's immune system cells. Elizabeth Pennisi & Kathy A. Fackelmann, *HIV Toll: Over a Billion White Cells a Day: Virus Overwhelms CD4 T-Cells*, 147 Science News 21 (1995). It continues to reproduce, "wearing away at the immune system" until the final, fatal stages of the disease. *Runnebaum* v. *Nationsbank of Maryland, N.A.*, 123 F.3d 156, 180 (4th Cir. 1997) (en banc) (Michael, J., dissenting).

The ADA's implementing regulations, which receive deference unless they are "arbitrary, capricious, or manifestly contrary to the statute," *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984), define a "physical impairment" as, among other things, "any physiological disorder or condition * * * affecting * * * [the] hemic and lymphatic" systems. 28 C.F.R. § 36.104. The decimation of the white blood cells and lymphocytes by the virus clearly is a disorder affecting the hemic and lymphatic systems. *See Runnebaum*, 123 F.3d at 180 (Michael, J., dissenting); *Cain* v. *Hyatt*, 734 F. Supp. 671, 679 (E.D. Pa. 1990); *Doe* v. *Dolton Elem. School Dist. No. 148*, 694 F. Supp. 440, 444 (N.D. Ill. 1988). Further, the regulations themselves state that "HIV disease (whether symptomatic or asymptomatic)" is an impairment under the statute. 28 C.F.R. § 36.104. *See Abbott* v. *Bragdon*, 107 F.3d 934, 939 (1st Cir. 1997) (holding "unhesitatingly that HIV-positive status, whether symptomatic or asymptomatic, comprises a physical impairment under the ADA").

B. HIV Infection Substantially Limits the Major Life Activity of Reproduction

The Court of Appeals held, as have many other courts, that HIV infection "substantially limits" the "major life activity"

of "reproduction."[18] This Court should affirm that holding. Reproduction, and the "bundle of activities" that term encompasses, *Abbott*, 107 F.3d at 941, is a major life activity within the meaning of the ADA, and one that is substantially limited by HIV infection.

Neither the statute nor its implementing regulations set forth all possible "major life activities." The ADA's implementing regulations cite examples of major life activities as including "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 29 C.F.R. § 1630.2(i). The list is nonexclusive, however, and courts have found myriad other functions to be major life activities.[19] Thus, because there is no exhaustive definition of the statutory term, it must be construed "in accord[ance] with its ordinary or natural meaning." *Smith* v. *United States*, 508 U.S. 223, 228 (1993); *see also Chapman* v. *United States*, 500 U.S. 453, 462 (1991). The dictionary defines "major" as "greater in dignity, rank, importance, or interest: superior." *Webster's Third New International Dictionary* 1363 (1976); *see also Abbott*, 107 F.3d at 939 (plain meaning of the word "major" denotes "comparative importance"). Under the term's ordinary meaning, reproduction is a "major" life activity. Conceiving and bearing a child, and raising that child into an adult, are "greater in dignity, rank, importance [and] interest" than virtually any other human function, for bearing and rearing children ensures the continued existence of our species. *See Stanley* v. *Illinois*, 405 U.S. 645, 651 (1972) (rights to conceive and raise one's children are "basic civil rights of man") (quoting *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942)).

[18] *See Abbott*, 107 F.3d at 939; *Hernandez* v. *Prudential Life Ins. Co. of Amer.*, 977 F. Supp. 1160, 1163 (M.D. Fla. 1997); *Pacourek* v. *Inland Steel Co.*, 916 F. Supp. 797, 804 (N.D. Ill. 1996); *Erickson* v. *Board of Govs. of State Colleges and Univs.*, 911 F. Supp. 316, 323 (N.D. Ill. 1995); *Doe* v. *Kohn, Nast & Graf*, 862 F. Supp. 1310, 1320 (E.D. Pa. 1994); *Doe* v. *District of Columbia*, 796 F. Supp. 559, 568 (D.D.C. 1992); *Cain*, 734 F. Supp. at 679. The First Circuit properly rejected the contrary view. *See Krauel* v. *Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996); *Zatarain* v. *WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd mem.*, 79 F.3d 1143 (5th Cir. 1996).

[19] *See, e.g., Lowe* v. *Angelo's Italian Foods, Inc.*, 87 F.3d 1170, 1174 (10th Cir. 1996) (lifting); *Purcell* v. *Pennsylvania Dep't of Corrections*, 1998 WL 10236 at *8 (E.D. Pa. Jan. 9, 1998) ("communicat[ing] with others for extended periods of time"); *Mondzelewski* v. *Pathmark Stores, Inc.*, 976 F. Supp. 277, 279 (D. Del. 1997) (lifting and reaching); *Bartlett* v. *New York State Bd. of Law Examiners*, 970 F. Supp. 1094, 1117 (S.D.N.Y. 1997) (reading and writing); *Pahulu* v. *University of Kansas*, 897 F. Supp. 1387, 1391 (D. Kan. 1995) (interscholastic sports); *Silk* v. *City of Chicago*, 1997 WL 790598 at *7 (N.D. Ill. Dec. 17, 1997) (sleep).

There is likewise no question that HIV infection substantially limits this major life activity. Under the ADA's regulations, a "substantial limitation" is defined as either being "[u]nable to perform a major life activity that the average person in the general population can perform" or being "*[s]ignificantly restricted* as to the condition, manner or duration under which an individual can perform a particular major life activity" as compared to the average person in the general population. 29 C.F.R. § 1630.2(j)(1)(i), (ii). While HIV does not necessarily render infected individuals "unable" to reproduce or engage in intimate sexual activity, the virus "[s]ignificantly restricts" their ability to do so. HIV-positive men and women risk infecting their partners if they engage in intimate sexual activity. HIV-positive women who become pregnant also face an unacceptable risk of infecting their children.[20] Should they survive to puberty, children who are perinatally infected will confront all the reproductive limitations that adults do; but

[20] As noted above, if an HIV-positive woman becomes pregnant, chances are one in four that her child will also be infected, a risk that drops, but only to 8%, with AZT treatment. *See supra* at 8. As the Court of Appeals held, "no reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity." *Abbott*, 107 F.3d at 942.

the harsh fact is that most will not survive to bear children and raise them.[21]

As the courts below found, moreover, reproduction does not just encompass conception, gestation, and childbirth. It includes as well "the process of raising and caring for offspring." *Abbott* v. *Bragdon*, 912 F. Supp. 580, 586 (D. Me. 1995); *see also Abbott*, 107 F.3d at 941; *Erickson*, 911 F. Supp. at 322. HIV-positive parents (whether natural, foster, or adoptive) are substantially limited in their ability to rear their children. To this point, HIV infection is invariably and inevitably fatal. Because the life expectancy of an HIV-positive parent is far shorter than average, that parent's ability to raise his or her child to adulthood is substantially restricted. This impact of HIV infection on families, and on the lives of children of HIV-positive parents, is far from hypothetical. It is estimated that more than forty thousand children have already lost one or both parents to AIDS, and that, by the turn of the century, the number of children orphaned by AIDS in the United States alone will exceed eighty thousand.[22]

Importantly, HIV results in a substantial limitation of the major life activity of reproduction regardless of one's particular stage in life. In the ADA, Congress broadly prohibited discrimination against any person with a physical impairment that "substantially limits" one or more "major life activities." Congress prohibited such discrimination regardless of whether the specific life activity limited by the disability has any relation to the discriminatory act. For example, it would be unlawful for the petitioner in this case arbitrarily to refuse to

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[21] The shortened life expectancy of children should itself be considered a limitation on the major life activity of reproduction. *See infra* at 20-22.

[22] *See* Stephen W. Nicholas & Elaine J. Abrams, *The "Silent" Legacy of AIDS: Children Who Survive Their Parents and Siblings*, 268 J. Am. Med. Ass'n 3478, 3478 (1992); David Michaels & Carol Levine, *Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States*, 268 J. Am. Med. Ass'n 3456, 3458 (1992).

treat a blind person on the basis of that disability, regardless of whether he viewed blindness as having anything to do with dental treatment. Likewise, one cannot discriminate against a person with AIDS (a conceded disability) regardless of whether the discrimination has anything to do with the major life activities limited by that disease, or whether the discriminatory actor even knew of those limitations. The statutory definition was thus intended to denote those disabilities that are sufficiently serious to become the target of irrational animus, regardless of whether the animus is predicated on the limitations caused by the disability. *See* S. Rep. No. 116, 101st Cong., 1st Sess. at 23 (1990) (definition of disability intended as a means of excluding "[p]ersons with minor, trivial impairments").

These policies would not be served if the ADA's protection were extended only to a narrow class of individuals infected with HIV. Reproduction is a major life activity within the meaning of the ADA notwithstanding that it occurs, at most, only several times in an average person's life. It would be patently absurd, and would not comport with Congress' intent, to hold that the Act protects only those HIV-infected individuals who have the subjective intent of engaging in reproductive activities in the imminent future. Both children and adults with HIV have the same physical impairment, the impairment limits the potential reproductive activities of both groups in the same manner—regardless of their immediate subjective intentions—and both groups experience the same sort of invidious discrimination. There is no reason to conclude that the disease affects the lives of children less severely than those of adults.[23]

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[23] Under a restrictive definition of "reproduction" as affecting only those presently able to bear or raise children, a thirteen-year-old, HIV-positive girl who reaches puberty would, for a reason wholly unrelated to her illness, attain the ranks of the "disabled" subclass of HIV-infected people. Her friend of the same age who has not yet reached puberty, but who is also HIV-positive, would not be disabled and would be unprotected from discrimination based on her HIV status. Congress could not have intended such an arbitrary and irrational result.

The ADA was intended to cover disabilities, like HIV, which are so severe that by their very nature they substantially limit a major life activity of human beings. Because the virus can be transmitted to partners and children and because it invariably causes debilitation and eventually death, HIV infection necessarily results in a substantial limitation on reproductive activities as compared to the general population.[24] Children with HIV should not be excluded from the protections of the statute merely because they are not yet grown, a reason completely divorced from their fatal impairment or the discrimination it engenders.

C. HIV Infection Also Substantially Limits *All* Major Life Activities, Including Living Itself

The Court, however, should not focus narrowly on HIV's effect on the major life activity of reproduction. The virus, because it is invariably fatal, radically foreshortens an infected person's life span. Accordingly, HIV "substantially limits" *all* the "major life activities" of every infected person, because it substantially limits life itself.

Under the implementing regulations, a physical impairment is "substantially limiting" if, among other things, it significantly restricts the condition, manner or *duration* within which an individual can perform a major life activity. 29 C.F.R. § 1630.2(j)(1)(ii). As a matter of plain language, there can be no doubt that living itself is a "major life activity"—indeed, living and life activity are synonymous terms. There can also be no doubt that, for all HIV-infected individuals, the duration of their lives—and therefore the duration, condition and manner within which they can perform *all* major life activities—are substantially limited when compared to the general population. Compared to the duration,

[24] That is not the case for all physical impairments that affect major life activities. Certain impairments, like arthritis, may substantially limit major life activities of some people but may simply be a minor irritant for others. In such circumstances—unlike the necessarily substantial effect of HIV on reproduction—the severity of a physical impairment can only be judged by its effects in a particular factual setting.

condition and manner within which "the average person in the general population" can, for example, care for oneself, perform manual tasks, walk, see, hear, speak, breathe and learn, *see* 29 C.F.R. § 1630.2(i), HIV-positive people are significantly restricted in the most fundamental way imaginable. They die, and they die far earlier than persons who do not suffer from the disability.

That is not to say, however, that every physical impairment that has a demonstrable effect on life expectancy is necessarily a protected disability under the ADA. The terms of the statute cover only those physical impairments that *substantially* limit major life activities. Even with recent advances in treatment, HIV is still an incurable and inevitably fatal condition that substantially limits an infected person's life expectancy compared with that of the general population. Therefore it falls squarely within the statutory definition. Other impairments may or may not rise to that level of severity, depending on their specific circumstances.

HIV-positive children are perhaps most profoundly affected by the inevitably fatal path of the virus. The median survival age of children infected with HIV at birth has been estimated at 8.1 to 10.7 years. *See* Huiman X. Barnhart et al., *Natural History of Human Immunodeficiency Virus Disease in Perinatally Infected Children: An Analysis from the Pediatric Spectrum of Disease Project*, 97 Pediatrics 710 (1996). Thus, while most children and adolescents constantly plan for the future—what sports to play, what schools to attend, where to live and work, with whom to seek relationships—those infected with HIV are hobbled by a strict regimen of medical treatment[25] and by the knowledge that, unless a cure is found

[25] In addition to the limitation of the duration of life expectancy, the condition of the life of an HIV-infected child who is receiving antiretroviral therapy may also be substantially limited when compared to the general population. The recommended drugs for HIV can cause side effects such as pancreatitis, rash, headache, nausea, and fever. *See* F.M. Balis & David Poplack, *Drug Development and Clinical Pharmacology of Antiretroviral Drugs*, *in* Pediatric AIDS: The Challenge of HIV Infection in Infants, Children, and Adolescents 638 (Philip A. Pizzo, M.D. & Catherine

before they die, they will almost certainly not grow to adulthood, complete their schooling, have a career, or have children and grandchildren. Their ability to plan, to play, to go to school, to form intimate relationships, to travel, and to live the life of a normal child or adolescent is first restricted, and then eliminated altogether, by their disease.[26]

To hold that it is legal to discriminate against HIV-positive children on the basis of their physical condition is not only illogical; it is unfair. HIV infection does not distinguish among children and adults, fertile or infertile people, homosexuals or heterosexuals. It affects everyone in the same way. If only a narrow subset of those infected with HIV is considered "disabled" within the definition of the ADA, HIV-positive children, among others, will be unprotected from discrimination. Congress, which had the plight of these children well in mind when it passed the Act, did not intend the ADA to be applied so parsimoniously.

CONCLUSION

As noted above, one of the first reported cases involving HIV discrimination held that an HIV-positive child was a protected individual. *See supra* at 12-13. Although great advances have been made in treatment since that time, several things are unchanged. HIV infection is still fatal; hundreds of children are infected each year; and discrimination against people with HIV and AIDS persists in all areas of public life. This Court should affirm the judgment below, and make clear

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M. Wilfert, M.D. eds., 2d ed. 1994). Such side effects can be anticipated to limit the condition within which a child can perform many major life activities.

[26] *See Be A Friend: Children Who Live With HIV Speak* (Lori S. Weiner et al. eds., 1994) at 11 ("I often wonder how much longer in life I have. Sometimes I think I only have months to live. Other times I'm more hopeful, and I think I'll live at least a couple more years."); *id.* at 13 ("[I]f I didn't have AIDS * * * I would not have to get up at 11 pm or at 7 am to take medicine"); *id.* at 18 ("Being normal is not worrying every day about if and when you will get sick and about how people will treat you at that time. I would do anything so that I could be normal.")

that *all* individuals with HIV, whether exhibiting outward symptoms or not, children or adults, are deserving of and entitled to the protections of the ADA. The ADA was passed, in no small part, for them.

Respectfully submitted,

ALTHEA GREGORY
5500 Friendship Blvd.
Chevy Chase, MD 20815
(301) 951-3602

LYNN E. CUNNINGHAM*
Associate Professor of
Clinical Law
The Jacob Burns Community
Legal Clinics
The George Washington
University Law School
2000 G Street, N.W.
Suite 200
Washington, D.C. 20052
(202) 994-7463

* Counsel of Record

Counsel for Amicus Curiae

(14)

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In The

Supreme Court of the United States

October Term, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The First Circuit

BRIEF OF SENATORS HARKIN, JEFFORDS AND KENNEDY AND OF REPRESENTATIVES HOYER, OWENS AND WAXMAN AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

*Arlene Mayerson, Esquire
Holly Baldwin, Esquire
Disability Rights Education and Defense Fund
2212 Sixth Street
Berkeley, CA 94710
Telephone: (510) 644-2555

Cary LaCheen, Esquire
137 MacDougal Street
New York, NY 10012
Telephone: (212) 998-6674

Counsel of Record

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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INTEREST OF AMICI CURIAE*

The following Senators and Congressmen were primary authors and sponsors of the Americans with Disabilities Act and are leaders in shaping this nation's disability policy. Amici have an interest in ensuring that the fundamental principles of the ADA are not eroded by overly restrictive interpretations of the term "disability," which result in condoning the discriminatory practices the ADA was intended to prohibit.

Senator Tom Harkin was the chief sponsor and a principal author of the ADA. As Chair of the Subcommittee on Disability Policy of the Senate Committee on Labor and Human Resources, and floor manager, he was involved in all aspects of the passage of the ADA.

Congressman Steny H. Hoyer was the lead House co-sponsor of the ADA. He led the House passage of the legislation and was intimately involved in all aspects of its consideration.

Senator James M. Jeffords has authored or contributed to every piece of legislation affecting federal disability policy since 1974, including amendments to Section 504 of the 1973 Rehabilitation Act, and the ADA. He is currently the Chair of the Senate Labor and Human Resources Committee.

Senator Kennedy, a principal author of the ADA, was the Chair of the Senate Committee on Labor and Human Resources during its passage, and is now Ranking Minority Member. He has been a leader on HIV/AIDS issues, including assuring coverage in the ADA.

Congressman Major R. Owens was Chair of the Subcommittee on Select Education of the Committee of Education and Labor during the deliberations on the ADA and was involved in all deliberations in the House.

Congressman Henry A. Waxman was an original co-sponsor of the ADA, and Chair of the House Commerce Subcommittee on Health and the Environment during its passage. He has been a

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* The parties have consented to the filing of this brief.

Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *Amicus Curiae*, its members, or its counsel made a monetary contribution to the preparation and submission of this brief.

leader in promoting public health and civil rights legislation for people with HIV infection.

SUMMARY OF THE ARGUMENT

Although couched in an argument rejecting "per se" coverage of persons with asymptomatic HIV infection under the American with Disabilities Act, Petitioner and his amici are actually asking this Court to hold that these individuals are never protected from discrimination under the ADA. This result threatens the very core of the ADA, which is meant to ensure that people with physical or mental impairments are not denied an equal opportunity to contribute to and participate in community life based on myths, fears, and stereotypes about disability.

Petitioner's argument that individuals with asymptomatic HIV infection are not "substantially limited in a major life activity" relies on an overly restrictive and unfounded interpretation of the plain language of the statue and contradicts unequivocal Congressional intent to protect persons with both symptomatic and asymptomatic HIV infection from adverse treatment that is not based on objective medical fact.

The substantially limited language as carried over from Section 504 of the 1973 Rehabilitation Act was understood to distinguish "trivial impairments" from those that significantly impact a person's life. HIV infection clearly has a significant impact on the life of those diagnosed with this debilitating fatal disease.

Moreover, Congress did not limit the definition of disability to those with substantially limiting impairments. Petitioner and his amici simply ignore the third prong of the disability definition – "regarded as" – which was designed precisely to ensure that individuals with stigmatic conditions which invoke negative reactions in others would not be "vulnerable to discrimination on the basis of mythology . . . precisely the type of injury Congress sought to prevent." *School Board of Nassau County v. Arline*, 480 U.S. 273, 284 (1987).

In order to ensure that individuals with disabilities would have their conditions "evaluated in light of medical evidence . . . " *Arline* at 285, Congress adopted this Court's formulation of "direct

threat" in *Arline*. Since this case, like *Arline*, involves the risk of contagion, deference to public health officials is appropriate. There is nothing in the language or legislative history of the ADA which justifies deference to private health care providers who are defendants or on whom a defendant has relied.

ARGUMENT

I. THE DEFINITION OF DISABILITY IS BROAD IN ORDER TO ACHIEVE THE NON-DISCRIMINATION GOALS OF THE ADA

In its extensive deliberations on the Americans with Disabilities Act (ADA),[1] Congress heard testimony from a wide range of people with different disabilities about the many types of discrimination that limit equal opportunity to education, employment, public accommodations, and public services.[2] Congress also reviewed authoritative governmental,

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[1] The Senate Committee on Labor and Human Resources and the Senate Subcommittee on the Handicapped held five hearings on the bill. On September 7, 1989, the bill passed the Senate with overwhelming support by a vote of 76 to 8. In the House, over 20 hearings were held before four House committees subcommittees. The House and Senate Conference Committee convened twice. The conference bill passed by an overwhelming majority in both the House (by a vote of 377 to 28) and the Senate (by a vote of 91 to 6). The ADA was signed by President Bush on July 26, 1990.

[2] For example:

> . . . A young woman who has cerebral palsy told the Senators about a local movie theater that would not let her attend because of her disability. . . .
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> . . . A Vietnam veteran who had been paralyzed during the war and came home using a wheeelchair testified that . . . [he] could not get a job because of discrimination.
>
> . . . A woman testified that, when she lost her breast to cancer, she also lost her job and, as a person with a history of cancer, could not find another one. Parents whose small child

public health, and census reports which studied the status of people with disabilities, which all concluded that comprehensive civil rights legislation was necessary to combat pervasive discrimination against people with disabilities.[3]

Congress found that "discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, *health services*, voting, and access to public services," 42 U.S.C. § 12101(a)(3) (emphasis added), and that the purpose of the ADA is "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1).

Congress recognized that discrimination takes a variety of forms – outright exclusion, lack of access, application of outmoded eligibility criteria, and attitudinal barriers based on "false presumptions, generalizations, misperceptions, patronizing attitudes, ignorance, irrational fears and pernicious mythologies." H.R. Rep. No. 101-485, pt. 2, at 30, 1990 U.S.C.C.A.N. at 311; S. Rep. No. 101-116, at 7.

Comprehensiveness was the hallmark of the Americans with Disabilities Act. As stated by then Attorney General Thornburgh, on behalf of President Bush:

> One of the (the ADA bill's) most impressive strengths is its comprehensive character. Over the last 20 years, civil rights laws protecting disabled

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had died of AIDS testified about how they could not find an undertaker who would bury their child. . . .

Arlene Mayerson, *The History of the ADA, in Implementing the Americans with Disabilities Act: Rights and Responsibilities of All Americans*, 17, 23 (Lawrence O. Gostin & Henry A. Beyer eds., 1993) (citations omitted). For a review of testimony, see H.R. Rep. No. 101-485, pt. 2, at 28-49 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 310-31; S. Rep. No. 101-116, at 5-20 (1989).

[3] The Committee Reports cite a variety of reports relied on by Congress. *See* H.R. Rep. No. 101-485, pt. 2, at 28, 1990 U.S.C.C.A.N. at 310; S. Rep. No. 101-116, at 6.

> persons have been enacted in piece-meal fashion. Thus, existing Federal laws are like a patchwork quilt in need of repair. There are holes in the fabric, serious gaps in coverage that leave persons with disabilities without adequate civil rights protections.

H.R. Rep. No. 101-485, pt. 2, at 48, 1990 U.S.C.C.A.N. at 330; S. Rep. No. 101-116, at 19.

Congress' intent was to ensure that all decisions based on disability, present, past, or perceived, were guided by facts, not myths, fears, and stereotypes. As stated by Senator Dole:

> We have included in this legislation all people with all disabilities, no matter how misunderstood because that is what this bill is about – replacing misunderstanding with understanding.

136 Cong. Rec. S9695 (daily ed. July 13, 1990) (statement of Sen. Dole).

Petitioner's argument that, in passing the ADA, Congress intended to condone discrimination against an individual with asymptomatic HIV infection based on unfounded fear of contagion, threatens the very core of the ADA. With the advance of medical technology, many individuals with a variety of disabilities from epilepsy to schizophrenia are or will become asymptomatic.[4] To argue that Congress intended to strip them of anti-discrimination protection for this reason is not only illogical, but also totally ignores Congress' recognition that disability status alone often invokes discrimination.[5] Congress was well aware that people with HIV infection, whether symptomatic or not, face pervasive discrimination due to fear of contagion. The history of the ADA demonstrates that Congress saw this type of discrimination as the same as, not

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[4] It is for this reason that the Committee Reports and authoritative agency regulations require limitations to be assessed without regard to mitigating measures. *See* H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 333; S. Rep. No. 101-116, at 23; 29 C.F.R. Pt. 1630, App., § 1630.2(j).

[5] *See* discussion of "regarded as" prong, *infra* pp. 13-22.

different from, the types of discrimination faced by people with a wide variety of disabilities.

In determining who would be protected by the ADA, Congress adopted the definition of "handicap" under Section 504 of the Rehabilitation Act of 1973.[6] A "disability" is defined with respect to an individual in three ways:

> (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
>
> (B) a record of such an impairment; or
>
> (C) being regarded as having such an impairment.

42 U.S.C. § 12102(2).[7]

This Court reviewed the history of the Section 504 definition in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987). Prior to 1974, the definition of handicap was tied directly to employability. *See id.* at 279 n.3. As noted in *Arline*, the definition was expanded in 1974 to address "the range of discriminatory practices in housing, education, and health care programs, which stemmed from stereotypical attitudes and ignorance about the handicapped." S. Rep. No. 93-1297, at 16, 37-38, 50, *cited in Arline* at 279 n.3.

The agency responsible for promulgating the Section 504 regulations, concluded that a specific list of conditions, which would constitute handicaps, was not possible because it would be difficult to ensure the "comprehensiveness of any such list." 45 C.F.R. Pt. 84, App. A, p. 310 (1985) *cited in Arline*, 480 U.S. at 280 n.5. Moreover, in response to comments that the definition was unreasonably broad, the agency found that

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[6] As explained in the Committee Reports, "[n]o change in definition or substance is intended nor should be attributed to the change in phraseology [from the term "handicap" to "disability."]." H.R. Rep. No. 101-485, pt. 2, at 51, 1990 U.S.C.C.A.N. at 332; S. Rep. No. 101-116, at 21. *See also* H.R. Rep. No. 101-485, pt. 3, at 26 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 449.

[7] This definition is often referred to as a three-prong definition. As discussed *infra*, Congress also carved out specific exclusions to the definition of disability in the ADA. *See* p. 22.

the broad regulatory definition "is inherent in the statutory definition." *Arline*, 480 U.S. at 280 n.5.

As this Court stated in *Arline*, "the definition of 'handicapped individual' is broad, but only those individuals who are both handicapped *and* otherwise qualified are eligible for relief." *Id.* at 285. This Court emphasized that without a broad definition of disability, individuals with disabilities would never have the opportunity to have their qualifications objectively evaluated, leaving them "vulnerable to discrimination on the basis of mythology – precisely the type of injury Congress sought to prevent." *Id.*

As argued below, Congress intended people with HIV infection, symptomatic or not, to be protected against discrimination based on fear of contagion. The substantially limited language carried over from Section 504 was understood to distinguish "trivial impairments" from those that significantly impact a person's life. H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 334; S. Rep. No. 101-116, at 23. No one could seriously argue that HIV infection does not have a significant impact on the life of those diagnosed with this debilitating fatal disease.[8]

Moreover, Congress did not limit the definition to those with present substantially limiting impairments. Rather, Congress recognized that in order to achieve its purpose, the ADA needed to protect those who were not currently substantially limited but who have a history of a disability or whose physical or mental condition invoked negative reactions in others.[9] *See* 42 U.S.C. § 12102(2)(b)-(c).

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[8] In addition, any argument that Congress intended to exclude individuals with asymptomatic HIV infection from coverage under the ADA is belied by the plain language of the statute. The language of the ADA, itself, demonstrates that Congress knew how to exclude disabilities from ADA coverage when it wished to do so. *See* discussion *infra* p. 22.

[9] For example, as pointed out in *Arline*, " 'irrational fears or prejudice on the part of employers or fellow workers' . . . make it difficult for former cancer patients to secure employment." *Arline*, 480 U.S. at 284

As Petitioner states in his brief, this Court has "[o]ver and over . . . stressed that '[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.' " Pet. Brief at 27, *quoting United States Nat'l Bank of Or. v. Indep. Ins. Agents of N. America*, 508 U.S. 439, 455 (1993). That said, Petitioner proceeds to apply a hypertechnical and incomplete interpretation to the definition of disability that would wholly defeat Congressional purpose and intent in passing the ADA. It is absolutely impossible to read the language and legislative history of the ADA and come to the conclusion that Congress condoned adverse treatment of people with HIV infection without reference to medical reality.

Petitioner's attempt to cast his argument as a mere rejection of "per se" coverage is misleading. Under Petitioner's case-by-case approach, individuals with asymptomatic HIV infection would always lose because according to Petitioner asymptomatic HIV infection, by definition, does not substantially limit major life functions. Pet. Brief at 3. In other words, Petitioner and his amici argue for "per se" non-inclusion of persons with asymptomatic HIV infection.

The "per se" characterization is a misnomer, in any case. People with certain disabling conditions will always be covered by the first "substantially limited" prong, not because the analysis is discarded, but because the condition itself is inherently substantially limiting. Moreover, an individual who has a physical or mental condition that is stigmatized and results in adverse treatment is covered by the third "regarded as" prong. Therefore, a person with HIV infection, who like Ms. Abbott, experiences discrimination because of fear of contagion is covered by the ADA. This is what Congress intended – this is the only way that the Congressional purpose to prohibit actions based on myths, fears, and stereotypes can be realized. Any other result would do violence to the "object and

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(*quoting* 123 Cong. Rec. 13515 (1977) (statement of Sen. Humphrey)). *See* "Regarded As" argument, *infra* pp. 13-22.

policy" of the ADA. *United States Nat'l Bank of Or.*, 508 U.S. at 455.

II. HIV INFECTION FALLS WITHIN THE PLAIN LANGUAGE OF THE STATUTORY DEFINITION OF "DISABILITY".

While the Petitioner apparently concedes that HIV infection is an impairment, Petitioner argues that asymptomatic HIV infection can never be a disability under the ADA. This argument would nullify not only the unequivocal intent of Congress, but also all agency regulations implementing the statute. Moreover, in Petitioner's attempt to persuade the Court that Congress condoned discrimination against people with HIV infection based on contagion, unless they are symptomatic, Petitioner fails to acknowledge the full definition of disability, including the "regarded as" prong of the definition. Whether under the first prong or the third prong, it is clear that people who face discrimination based on HIV status are covered by the ADA.

A. HIV Infection Falls Within the First Prong of the Definition of Disability Because HIV Infection – Symptomatic or Asymptomatic – Substantially Limits Major Life Activities.

As noted above, the first prong of the definition of "disability" defines the term as a "physical or mental impairment that substantially limits one or more . . . major life activities." 42 U.S.C. § 12102(2)(a). The term "major life activities" must be interpreted broadly enough to encompass the full range of disability experiences intended to be covered by the ADA. As repeatedly stated in the Committee Reports, the purpose of the substantial limitation language was to distinguish "trivial" impairments.

> Persons with minor, trivial impairments, such as a simple infected finger, are not impaired in a major life activity. A person is considered an individual with a disability for purposes of the first prong of the definition when the individual's important life

> activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people.

H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 334; S. Rep. No. 101-116, at 23.

As anyone diagnosed with HIV infection knows, and as Congress was well aware, a positive HIV test changes everything.[10] Numerous legislators stated their understanding of the pervasive effect of an HIV diagnosis. In the words of Senator Kennedy:

> People with HIV disease are individuals who have any condition along the full spectrum of HIV infection – asymptomatic HIV infection, symptomatic HIV infection or full-blown AIDS. These individuals are covered under the first prong of the definition of disability in the ADA, as individuals who have a physical impairment that substantially limits a major life activity. . . . [A]lthough the major life activity that is affected at any point in the spectrum by the HIV infection may be different, there is a substantial limitation of some major life activity from the onset of HIV infection.

136 Cong. Rec. S9696 (daily ed. July 13, 1990) (statement of Sen. Kennedy); *accord* 136 Cong. Rec. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens); *id.* at H4624 (statement of Rep. Edwards); *id.* at H4626 (statement of Rep. Waxman).

Petitioner's argument is nothing more than a rehashing of the argument presented to and rejected by this Court in *Arline*. In that case, the petitioner argued that an adverse decision based on fear of contagion was not disability-based

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[10] From the moment of contraction, HIV-infected individuals must pay constant and diligent attention to developing proper sleep and eating patterns, regulating weight in anticipation of future possible weight loss, avoiding dangerous activities that might threaten others with exposure to the virus, and avoiding exposure that might result in reactivation of prior infections for which the individual has a compromised ability to respond. Moreover, all life decisions are influenced greatly by the known progressive and fatal nature of the disease.

discrimination because it was not based on "real or perceived diminution of an individual's capabilities." *Arline*, 480 U.S. at 281 n.6. Supporting the petitioner, the government argued that since it is possible for a person to be capable of spreading a disease without having a "physical impairment," discrimination based on contagion could never be disability-based discrimination. The government in *Arline* incorrectly used asymptomatic HIV infection as such an example. *See id.* at 282 n.7. Since that time, the unanimous opinion of public health officials, Congress, and the implementing agencies is that HIV infection is an impairment. *See* S. Rep. No. 101-116, at 22; 29 C.F.R. Pt. 1630, App., § 1630.2(j). Petitioner has conceded this point. Pet. Brief at 18. Therefore, the words of *Arline* apply with equal force here.

> We do not agree with Petitioners that, in defining a handicapped individual under § 504, the contagious effects of a disease can be meaningfully distinguished from the disease's physical effects on a claimant in a case such as this. [Respondent's] contagiousness and her physical impairment each resulted from the same underlying condition. . . . It would be unfair to allow [Petitioner] to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and then use that distinction to justify discriminatory treatment.

480 U.S. at 282.

Finally, contrary to Petitioner's claim, there is no reason in the language of the ADA not to recognize reproduction as a major life activity. Congress did not intend the term to be restrictive, or to give certain types of disabilities preference over others because of the major life function affected. Indeed, a finding that reproduction or intimate sexual activities are *not* major life activities will thwart the will of Congress.

The Committee Reports repeatedly cite with approval a memorandum written by the Office of Legal Counsel of the

Department of Justice interpreting Section 504 and its application to individuals with HIV infection:[11]

> As noted by the U.S. Department of Justice, . . . a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term "disability" because of a substantial limitation to procreation and intimate sexual relationships.

H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 334 (*citing* OLC Memorandum at 9-11). *See also* H.R. Rep. No. 101-485, pt. 3, at 28 n.18, 1990 U.S.C.C.A.N. at 451; S. Rep. No. 101-116, at 22. Since it is clear that Congress and the Department of Justice concluded that sex and reproduction are major life activities, and everyone involved in the legislation was aware of this, Petitioner and his amici's contrary view is not persuasive.[12]

The agencies charged with implementing the ADA have also concluded that HIV infection substantially limits major

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[11] *Memorandum of Office of Legal Counsel to the President Regarding Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals*, 1988, *reprinted in Americans with Disabilities Act of 1988: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources*, 101st Cong. 338-366 (1989) [hereinafter OLC Memorandum]. The Petitioner cites to an earlier D.O.J. memorandum, concluding that HIV is not a "handicap" under 504. Pet. Brief at 22 n.15. What Petitioner fails to convey, however, is that the Cooper memorandum cited was actually the background for the Government's position in *Arline*, which was rejected by this Court. *See Arline*, 480 U.S. at 282 n.7.

[12] As explained by Justice Breyer:

> [A] fairly common function of legislative history [is] explaining specialized meanings of terms or phrases in a statute which were previously understood by the community of specialists (or others) particularly interested in a statute's enactment.

Stephen Breyer, On the Uses of Legislative History in Interpreting Statutes, 65 S. Cal. L. Rev. 845, 853 (1992).

life activities.[13] See the Department of Justice Title III implementing regulations, 28 C.F.R. Pt. 35, App. A, § 35.104, and the Equal Employment Opportunity Commission ["EEOC"] Title I implementing regulations, 29 C.F.R. Pt. 1630, App., § 1630.2(j). *See also* 28 C.F.R. § 36.104; *id.* at Pt. 36, App. B, § 36.104.

Petitioner's argument that "[a]symptomatic HIV-infection is not a substantial physical limitation on [the] ability to have intimate sex and/or reproduce," Pet. Brief at 13, is quite astounding. The risk of transmitting HIV to offspring is real and substantial. In the words of the First Circuit, "[n]o reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity." *Abbott v. Bragdon*, 107 F.3d 934, 942 (1st Cir. 1997).

B. HIV Infection Falls Within the Third Prong of the Definition of Disability.

In arguing that HIV is not a disability under the ADA, Petitioner ignores the "regarded as" prong of the ADA definition of disability. Even if this Court does not find asymptomatic HIV infection to be a disability under the first prong of the definition, it is clear that the "regarded as" prong of the definition, as explained in *Arline*, was enacted precisely to address the type of discrimination faced by Ms. Abbott in this case. There is no dispute that Petitioner's reason for not treating Ms. Abbott was fear generated by her impairment.[14]

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[13] The DOJ and EEOC regulations are entitled to judicial deference. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844-45 (1984) ("[c]onsiderable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer . . . "); *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 634 (1984) ("This Court generally has deferred to contemporaneous regulations issued by the agency responsible for implementing a congressional enactment.").

[14] As argued above, Congress considered HIV infection to be substantially limiting. However, for purposes of the "regarded as" analysis

A review of the legislative history leaves no doubt that Congress intended the "regarded as" prong to prohibit discrimination based on *disability status*. As this Court stated in *Arline*,[15]

> [t]o combat the effects of erroneous but nevertheless prevalent perceptions about the handicapped, Congress expanded the definition of "handicapped individual" so as to preclude discrimination against "[a] person who has a record of, or is *regarded as having an impairment [but who] may at present have no actual incapacity at all.*"

480 U.S. at 279 (emphasis added).[16]

Quoting from the *Arline* decision, the ADA Committee Reports adopt the rationale articulated by this Court as follows:

> By amending the definition of "handicapped individual" to include not only those who are actually physically impaired, but also those who are regarded as impaired and who, as a result, are substantially limited in a major life activity, Congress acknowledged that *society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment.*

Arline, 480 U.S. at 284 (emphasis added), *cited in* H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; S. Rep. No. 101-116, at 24.

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it is sufficient that Petitioner adversely reacted to her impairment, which Petitioner does not dispute.

[15] *See supra* note 6. Congress adopted the definition of disability from the definition of handicap under Section 504.

[16] The Court specifically noted that the previous definition was

> "too narrow to deal with the range of discriminatory practices in housing, education, and *health care programs* which stemmed from stereotypical attitudes and ignorance about the handicapped."

Arline, 480 U.S. at 279 n.3 (*citing* S. Rep. No. 93-1297, at 16, 37-38, 50) (emphasis added).

As reflected in the Committee Reports, Congress intended to adopt the long-standing definition of the "regarded as" prong under Section 504, as follows:

> (iv) "Is regarded as having an impairment" means
>
> (A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a [covered entity] as constituting such a limitation;
>
> (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or
>
> (C) has none of the impairments defined in [prong 1] but is treated by a [covered entity] as having such an impairment.

H.R. Rep. No. 101-485, pt. 3, at 29, 1990 U.S.C.C.A.N. at 452, *citing* 45 C.F.R. § 84.3(j)(2)(iv), (incorporated in ADA regulations at 29 C.F.R. at 1630 App. A § 1630.2(1) (1997)). *See also* H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; S. Rep. No. 101-116, at 23.

Subsection (B) is intended to cover stigmatic impairments, such as HIV infection, which invoke reactions based on ignorance, fear, and stereotypes. As this Court recognized in *Arline*,

> Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.
>
> * * *
>
> The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments: the definition of "handicapped individual" is broad, but only those individuals who are

> both handicapped *and* otherwise qualified are eligible for relief.

480 U.S. at 284-85.[17]

While conceding "regarded as" coverage on one hand, Petitioner undercuts coverage by arguing that an individual defendant would need to regard the infection as affecting a "pertinent" major life activity. Pet. Brief at 18. In Petitioner's formulation, this would be impossible, because it would be extremely unlikely that a person with asymptomatic HIV infection would be adversely treated because the defendant viewed her as substantially limited in walking, breathing, hearing, etc. Rather, the adverse treatment would be based on fear of contagion, as in this case.

Petitioner's interpretation of the "regarded as" prong makes a mockery of Congressional intent. Under his formulation, a school board would be free to exclude a child with asymptomatic HIV infection from school on the mistaken belief that the child would infect classmates, so long as the school board did not view the child as substantially limited in a "pertinent life activity." The numerous statements of members expressing outrage about the plight of Ryan White and other children with HIV infection belie such an assertion.[18]

Likewise, it makes no sense for Petitioner to argue that Ms. Abbott is not covered under the "regarded as" prong of the definition because he did not perceive her to be limited in a "pertinent major life activity." Petitioner viewed Ms. Abbott

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[17] In *Arline* this Court interpreted Section 504 without any explicit references in the legislative history to contagious diseases. Any concerns of the *Arline* dissent in this regard are not applicable here because Congress made its intent to cover individuals with HIV infection under the ADA explicit. *See* 480 U.S. at 289-90; *see also infra* pp. 23-26 (discussing legislative history concerning HIV infection).

[18] *See, e.g.*, 136 Cong. Rec. S7442 (daily ed. June 6, 1990) (Ronald Reagan: "We Owe It to Ryan"); 136 Cong. Rec. H2479 (daily ed. May 17, 1990) (statement of Rep. McCloskey); *id.* at H2480 (statement of Rep. McDermott); *id.* at H2481 (statement of Rep. Jontz).

as substantially limited in the ability to receive routine medical care. Petitioner would like to have it both ways. He cannot refuse treatment based on her medical condition and then come to court and argue that he did not regard her medical condition as "substantially limiting" enough to bring her under the protection of the ADA. This argument simply ignores the language and purpose of the "regarded as" prong.

Petitioner's example of "Magic" Johnson and Greg Louganis as super-heroes who could not possibly be "disabled," Pet. Brief at 3-4, misses the whole purpose of the "regarded as" prong of the disability definition. The ADA recognizes that many people with physical or mental impairments are extremely capable, but are stymied in their efforts to participate in society because of the views of others. If "Magic" Johnson or Greg Louganis were denied medical services or entrance to a restaurant because of the unfounded fear of HIV transmission, it would be irrelevant whether they could win gold medals at the Olympics. That is the whole point of the "regarded as" prong, to assure that people have an opportunity to be judged on their merits, not on the misguided perceptions or prejudices of others.

Congress noted the particular importance of the "regarded as" prong of the definition for those with "stigmatic conditions." H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; S. Rep. No. 101-116, at 24. The most commonly cited example of a person covered by the "regarded as" prong in the legislative history is a "burn victim." H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; H.R. Rep. No. 101-485, pt. 3, at 30, 1990 U.S.C.C.A.N. at 453; S. Rep. No. 101-116, at 24. Again, Congressional intent would be subverted if Petitioner could turn down all burn victims and then argue that he did not view them as substantially limited in "pertinent major life activities," *i.e.*, the ability to walk, hear, see, etc.

In fact, discrimination against many of the disabilities that Congress intended to cover would be condoned by Petitioner's logic. As this Court noted in *Arline*,

> Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have

> faced discrimination based on the irrational fear that they might be contagious.

480 U.S. at 284. According to Petitioner, individuals with epilepsy or cancer, who are not substantially limited in a "pertinent life activity" could be turned away because of fear of contagion. This inequity was condemned in *Arline*:

> Allowing discrimination based on the [perceived] contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504, which is to ensure that handicapped individuals are not denied . . . benefits because of the prejudiced attitudes or the ignorance of others.

Id.

There can be no doubt that people with HIV infection are substantially limited as a result of the attitudes of others. As the Commissioner to the National Commission on AIDS stressed in his testimony before Congress, "[r]emember, Ryan White, denied entry to school. The Ray family, burned from their home. A woman with AIDS denied entry with her children to a public swimming pool. A bright young attorney forced into poverty because he was fired from his job." *Americans with Disabilities Act of 1989: Hearings Before the House Subcomm. on Civil and Constitutional Rights and Comm. on the Judiciary*, 101st Cong., 1st Sess. 171 (1989) (statement of Rev. Scott Allen, Commissioner, National Commission on AIDS). Social exclusion of this nature most certainly materially limits major life activities. *See Cain v. Hyatt*, 734 F. Supp. 671, 678 (E.D. Pa. 1990) ("HIV-positive individuals are unjustifiably and 'widely stereotyped as indelibly miasmic, untouchable, physically and morally polluted.' ").[19]

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[19] *See also Harris v. Thigpen*, 941 F.2d 1495, 1521 (11th Cir. 1991) (HIV-infected prisoners are "categorically separated from virtually all aspects of general population institutional life"); *Austin v. Pennsylvania Dep't of Corrections*, 876 F. Supp. 1437, 1465 (E.D. Pa. 1995) (noting that in addition to impairing multiple body systems, HIV infection substantially limits major life activities "by . . . the fear it inspires in others"); *Doe v. District of Columbia*, 796 F. Supp. 559, 565 (D.D.C. 1992) (Defendant

Members of Congress recognized the importance of HIV coverage to combat the stigma attached to the disease, particularly fear of contagion:

> With this measure, we call for an end to finger pointing and fear mongering about AIDS. We know with great certainty how this disease is and is not transmitted. There is no scientific or medical reason to shun people with AIDS or HIV disease.

135 Cong. Rec. S10789 (daily ed. Sept. 7, 1989) (statement of Sen. Kennedy).

Perhaps nothing better illustrates the purpose of the "regarded as" prong of the definition of disability than the floor debates on the Chapman amendment. Under this proposal, food-handling employees diagnosed with an infectious disease would have been exempt from certain provisions of the ADA.[20] According to Representative Chapman, the proponent of the amendment:

> the bill as currently drafted will not provide an employer the flexibility to move an employee out of food-handling position [sic] if that employee were diagnosed as having an infectious or contagious disease such as AIDS. The reality is that many Americans would refuse to patronize any food

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testified that he " 'would be crazy' not to take the public's fear of HIV and AIDS into account."); *Cain v. Hyatt*, 734 F. Supp. 671, 680 (E.D. Pa. 1990) ("The particular associations AIDS shares with sexual fault, drug use, social disorder, and with racial minorities, the poor, and other historically disenfranchised groups accentuates the tendency to visit condemnation upon its victims."); *Doe v. Dolton Elementary School Dist. No. 148*, 694 F. Supp. 440, 444 (N.D. Ill. 1988) ("Surely no physical problem has created greater public fear and misapprehension than AIDS."); *Ray v. School Dist. of DeSoto County*, 666 F. Supp. 1524, 1535 (M.D. Fla. 1987) ("The Court recognizes the concern and fear which is flowing from this small community. . . . However, the Court may not be guided by such community fear. . . . ").

[20] *See* H.R. Conf. Rep. No. 101-596, at 61 (1990), *reprinted in* 1990 U.S.C.C.A.N. 565, 570.

> establishment if an employee were known to have a communicable disease.

136 Cong. Rec. H2478 (daily ed. May 17, 1990) (statement of Rep. Chapman).

From the start, Representative Chapman admitted that there was no evidence that AIDS could be transmitted in the process of handling food. *See id.* The whole debate centered on the fact that restaurants would lose patrons because of the erroneous belief that the disease could be transmitted through food. *See id.* In arguing against the amendment, Representative McDermott stated:

> . . . the amendment is not about the reality of contagious disease. It is about the fear of contagious disease. Let us be honest: It is about the fear of AIDS.
>
> * * *
>
> A few years ago, a school board in Indiana told Ryan White that he could not go to school with other children. It was not that the school officials thought Ryan would infect the others, they said, it was that some parents were afraid he would. That school system made a policy decision in response to fear and prejudice. By the time Ryan White died last month, everyone knew better.

136 Cong. Rec. H2480 (daily ed. May 17, 1990) (statement of Rep. McDermott).

The Bush Administration agreed.

> Dr. Sullivan, the Secretary of Health stated: 'Any policy based on fears and misconceptions about HIV will only complicate and confuse disease control efforts without adding any protection to public health. We need to defeat discrimination rather than to submit to it.'

136 Cong. Rec. S9686 (daily ed. July 13, 1990) (statement of Sen. Harkin).

In conference, the Chapman Amendment was replaced with a provision that rejected decisions based on "false perceptions" requiring decisions about food handling to be based

on "valid scientific and medical analysis and using accepted public health methodologies. . . . " H.R. Conf. Rep. No. 101-596, at 62, 1990 U.S.C.C.A.N. at 570. As stated by Senator Hatch, the author of the substitute amendment, "this does away with people's fears and it says let science govern, which is the only way to do it." 136 Cong. Rec. S9538 (daily ed. July 11, 1990) (statement of Sen. Hatch).[21]

The debates and resolution of the Chapman amendment make no sense in Petitioner's view of HIV coverage. According to the Petitioner's circular analysis, a restaurant owner could not only transfer but also fire an individual with HIV infection who handled food, so long as the owner did not regard the infection as affecting a "pertinent life activity." Pet. Brief at 18. Yet in defeating the Chapman amendment, Congress expressly rejected such actions by restaurant owners.

People with both symptomatic and asymptomatic HIV infection are equally situated, vis-a-vis contagion. As evidenced by the debates concerning the Chapman amendment, Congress intended that a person with HIV infection, whether or not symptomatic, who is turned away because of fear of contagion be given an opportunity to have the adverse treatment evaluated under objective standards pursuant to the ADA. Nothing could better exemplify the "object and policy"

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[21] *See also* 136 Cong. Rec. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens) ("[T]he original amendment offered by Congressman Chapman responded to public fear and misperception regarding people with HIV diseases by legitimizing those fears. . . . I am pleased that we have arrived at an acceptable resolution of this issue, particularly because the ADA offers such critical protection to people with HIV disease in a range of areas."); *id.* at H4624 (statement of Rep. Edwards). Without a doubt, there is fear and misperception regarding the threat posed by people with Acquired Immune Deficiency Syndrome (AIDS) and other forms of Human Immunodeficiency Virus (HIV) disease. But the proper response to such fear and misperception is not to legitimize them by allowing such false perceptions to determine who can hold certain jobs. Rather, the proper response is that taken in the Hatch amendment, which the conferees have adopted.").

of the "regarded as" prong of the definition. *United States Nat'l Bank of Or.*, 508 U.S. at 455.

C. HIV Infection is Not One of the Conditions Explicitly Excluded from the Statutory Definition of Disability Under the ADA.

In perhaps the most disingenuous argument presented by Petitioner, Petitioner argues that Congress rejected HIV coverage because "HIV infection is nowhere mentioned in the legislation passed after extensive debate." Pet. Brief at 26 n.18.

As stated above, the ADA adopted the approach taken in the Rehabilitation Act, which rejected listing specific conditions because of the "difficulty of ensuring the comprehensiveness of any such list." 45 C.F.R. Pt. 84 App. A, p. 310 (1985), *cited in Arline*, 480 U.S. at 280 n.5. However, while the ADA does not list exemplary conditions or diseases that fit within the disability definition, the statute does list those conditions that do *not* constitute a disability under the ADA.[22] These examples show that Congress clearly knew how to exempt certain conditions or diseases from coverage under the ADA when it so desired. Moreover, in light of the abundant testimony before Congress on the subject of HIV and AIDS, it speaks volumes that the exemptions cited in the statute do not include mention of HIV infection. Not only did Congress choose not to exclude asymptomatic infection from coverage, it made certain that the exclusions would not affect HIV coverage.

The following colloquy between Senators Helms and Harkin could not be clearer.

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[22] Under 42 U.S.C. § 12208, being a transvestite is not a disability. Similarly, under 42 U.S.C. § 12211(a), "homosexuality and bisexuality are not impairments and as such are not disabilities." Section 12211(b) further clarifies conditions that do not qualify as disabilities, including transsexualism, exhibitionism, compulsive gambling, pyromania, and "psychoactive substance use disorders resulting from current illegal use of drugs." 42 U.S.C. § 12211(b).

> MR. HELMS: I do not understand why, for example, you went down the road of including in your definitions people who are HIV positive, because 85 percent or more of the HIV positive people in this country are known to be drug users or homosexual or both. [sic]
>
> MR. HARKIN: Then I respond to the Senator that they are not covered under this bill on the basis of their homosexuality or drug use.
>
> MR. HELMS: The Senator better read his committee report, because it says they are covered.
>
> MR. HARKIN: They are covered on the basis of their HIV infection but not on the basis of being current drug users.

135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) (statements of Sens. Helms and Harkin).

> The Judiciary Report reiterates this understanding: Individuals who are homosexual or bisexual and are discriminated against because they have a disability, such as infection with the Human Immunodeficiency Virus, are protected under the ADA. The Committee specifically rejected amendments to exclude homosexuals with certain disabilities from coverage.

H.R. Rep. No. 101-485, pt. 3, at 75, 1990 U.S.C.C.A.N. at 498.

III. THE LEGISLATIVE HISTORY OF THE ADA MAKES CLEAR THAT CONGRESS INTENDED HIV INFECTION TO BE A COVERED "DISABILITY" UNDER THE ACT.

Congressional intent to cover people with both symptomatic and asymptomatic HIV infection is unambiguous. Congress repeatedly affirmed this intent – in both the Committee Reports and the floor statements – in order to ensure that people with HIV disease were not subject to discrimination based on fear or ignorance.

First, the Committee Reports confirm Congress' intent to use the standards and interpretations under Section 504,

including this Court's discussion of the definition of "disability" in *Arline*. Prior to enactment of the ADA, the agency responsible for implementing Section 504[23] and all courts addressing the issue concluded that HIV infection was a covered "handicap." *See infra* note 27. It is well established that when Congress adopts a new law incorporating sections of a prior law, Congress is presumed to be aware of prior judicial interpretations and to adopt them in re-enacting statutory language. *See Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978). *See also Keene Corp. v. United States*, 508 U.S. 200, 212-13 (1993) (where Congress re-enacts a statute that had been given a consistent judicial interpretation, such re-enactment generally includes the settled judicial interpretation).[24]

Congress knew that Section 504 was a powerful tool to combat discrimination based on fear and ignorance of HIV transmission. For example, in the 1980s children with HIV infection who had been terrorized by their community and excluded from school,[25] and a child who had been put in a glass enclosure in the back of the classroom,[26] were able to use Section 504 to combat myths, fears, and stereotypes about

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[23] Enforcement of Nondiscrimination on the Basis of Handicap in Department of Justice Programs, 48 Fed. Reg. 55996 (1983) (codified at 28 C.F.R. Pt. 39).

[24] This is most compelling here, as the ADA states that: "Nothing in the ADA shall be construed to provide a lesser standard than the standard applied under Title V of the Rehabilitation Act." 42 U.S.C. § 12201(a).

[25] *Ray v. School District of DeSoto County*, 666 F. Supp. 1524 (M.D. Fla. 1987). As stated by the *Ray* Court, "[t]he reality is that the Ray boys have already been dealt a hand not to be envied by anyone. The boys at their young ages are having to face two potentially life-threatening diseases. This is more than most people face in their entire adult lives. Denial of the opportunity to lead as normal an educational and social life as possible is adding insult to injury." *Id.* at 1535.

[26] *Martinez v. School Board of Hillsborough County*, 861 F.2d 1502, 1504 (11th Cir. 1988).

HIV infection. In fact, no court even considered the proposition that HIV infection may not be a covered handicap under Section 504.[27]

Congress not only relied on prior interpretations of Section 504, however; it expressly endorsed the conclusion of the Department of Justice memorandum that Section 504 applies to individuals infected with HIV.[28] In addition, it endorsed the recommendation of the Presidential Commission on the HIV Epidemic that HIV-infected individuals be covered under anti-discrimination legislation:

> As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination . . . will undermine our efforts to contain the HEV [sic] epidemic and will leave HIV-infected individuals isolated and alone.
>
> * * *
>
> Comprehensive Federal anti-discrimination legislation, which prohibits discrimination against persons with disabilities in the public and private sectors, including employment, housing, public accommodations and participation in government programs should be enacted. All persons with symptomatic or asymptomatic HIV infection should be clearly included as persons with disabilities who are covered by the anti-discrimination protections of this legislation.

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[27] *See, e.g., Doe v. Garrett*, 903 F.2d 1455, 1459 (11th Cir. 1990) (holding that infection with AIDS constitutes a handicap under Rehabilitation Act), *cert. denied*, 499 U.S. 904 (1991); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820, 825 (5th Cir. 1990) (assuming that HIV infection is an impairment protected by Section 504); *Chalk v. United States Dist. Court, Central Dist. of Cal.*, 840 F.2d 701, 705 (9th Cir. 1988) (assuming AIDS comes within Section 504).

[28] *See* discussion *supra* pp. 11-12.

H.R. Rep. No. 101-485, pt. 2, at 31, 48, 1990 U.S.C.C.A.N. at 313, 330 (citing *Report of the Presidential Comm. on the Human Immunodeficiency Epidemic*, June 1988, at 123); S. Rep. No. 101-116, at 8, 19.

Finally, as quoted throughout this brief, the record is replete with floor statements expressing the intent that HIV be a covered disability. *See supra* pp. 10, 19-21, 23. As the debates over the Chapman amendment make vividly clear,[29] even those who didn't approve of HIV coverage understood that the ADA prohibited discrimination on the basis of HIV infection, symptomatic or asymptomatic.[30]

IV. IN DETERMINING WHETHER AN INDIVIDUAL POSES A DIRECT THREAT UNDER THE ADA, COURTS SHOULD NOT DEFER TO PRIVATE HEALTH CARE PROVIDERS.

At the core of the ADA is the requirement that any adverse decision based on disability be judged by objective fact. Perhaps the most invidious stereotype faced by people with disabilities throughout the ages has been that they pose a danger to others. As noted by this Court in *Arline*, "[t]he isolation of the chronically ill and of those perceived to be ill or contagious appears across cultures and centuries, as does the development of complex and often pernicious mythologies about the nature, cause, and transmission of illness." 480 U.S. at 284 n.12 (citations omitted).

In order to ensure that individuals with disabilities were not assumed to be a danger without objective facts, Congress created the "direct threat" defense. 42 U.S.C. § 12182(b)(3). This defense protects people with disabilities from unfounded

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[29] *See* discussion *supra* pp. 19-21.

[30] In the words of one opponent of the ADA, "[W]ith the adoption of this act we are instantaneously going to bring within the definition of disabled person across this land every HIV carrier in America, every person with AIDS. Now that is not what my definition of disability should be including." 136 Cong. Rec. H4621 (daily ed. July 12, 1990) (statement of Rep. Dannemeyer).

adverse actions, while at the same time recognizing legitimate concerns for public safety. *See* H.R. Rep. No. 101-485, pt. 2, at 56-57, 1990 U.S.C.C.A.N. at 338-39; H.R. Rep. No. 101-485, pt. 3, at 45-46, 1990 U.S.C.C.A.N. at 468-69; S. Rep. No. 101-116, at 27.

This is not, however, a case that calls upon this Court to speculate about how a generally expressed Congressional intent would apply to the situation presented here. The exact issue presented in the third question certified in this case was decided by Congress when it enacted the direct threat defense based on the standard articulated in *Arline*.[31] *Arline* directly addressed the standard to be used in cases where the threat posed is infection. In those cases, the Court held that the question of whether a person with a disability poses a direct threat must be evaluated objectively given the state of medical knowledge, and that

> [i]n making these findings, courts normally should defer to the reasonable medical judgments of public health officials.

480 U.S. at 288. *See also id.* at 286 n.15.

While this Court also noted that *Arline* did not present, and it therefore did not address, the question of whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied, *see id.* at 288 n.18, this reference must be to the medical judgments of private physicians on matters *other* than the risk posed by a contagious disease. Otherwise, the Court's twice-mentioned statement that courts should defer to judgments of public health officials on issues of contagion would make little sense. Thus, Petitioner's attempt to construe *Arline* as leaving

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[31] *Section 101(8) – Direct Threat*

> The Committee intends to codify the direct threat standard used by the Supreme Court in *School Board of Nassau County v. Arline*.

H.R Rep. No. 101-485, pt. 3, at 34, 1990 U.S.C.C.A.N. at 457. *See also* H.R. Rep. No. 101-485, pt. 2, at 56-57, 1990 U.S.C.C.A.N. at 338-39; S. Rep. No. 101-116, at 27, 40.

open the question presented here is unsupportable. A rule cannot provide simultaneous deference to public health officials and employers' private physicians or physician defendants on the same determinations, because such judgments may conflict, as in this case.[32]

Nothing in the ADA or its legislative history supports the conclusion that Congress intended to create a different standard for private health care providers. Indeed, discrimination by health care providers against people with disabilities was one of the very harms the ADA was enacted to address.[33] Adopting the findings of a report by the U.S. Commission on Civil Rights, Congress concluded that discrimination against people with disabilities "persists in such critical areas as . . . medical treatment." H.R. Rep. No. 101-485, pt. 2, at 31, 1990 U.S.C.C.A.N. at 312; S. Rep. No. 101-116, at 8.

There is no principled way to distinguish between cases where the health care provider is a defendant and those where the defendant relies on a doctor as the basis for an adverse decision. Congress explicitly rejected giving deference to defendants' doctors. As stated in the House Committee on Education and Labor Report:

> [A]ny determination by a company physician can be challenged by evidence from the complainant's physician. Company doctors often are unfamiliar with certain disabilities and assume that there are barriers to employment which, in fact, do not exist. The complainant's own physician often has more knowledge about the effects of the disability on the individual being considered.

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[32] While it is not necessary to address the open question in this case, it should be noted that Congress's intent to cover doctor's offices in the same manner as other public accommodations is clear from the legislative history. As argued *infra*, deference to medical doctor defendants, or to defendants' doctors, was explicitly rejected.

[33] Offices of health care providers are specifically covered. *See* 42 U.S.C § 12181(7)(f).

H.R. Rep. No. 101-485, pt. 2, at 73, 1990 U.S.C.C.A.N. at 356.[34]

Moreover, the refusal by dentists and other health care providers to treat individuals with HIV was explicitly mentioned in the legislative history as an area of discrimination that the ADA was intended to remedy:

> The public accommodations title of the ADA will also offer necessary protection for people with HIV disease. This title prohibits discrimination in such areas as doctors' offices, *dentists' office* [sic], lawyers' offices, and various other service providers. *These are areas of society in which, unfortunately, people with HIV disease have faced discrimination.*

136 Cong. Rec. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens) (emphasis added).

The test adopted by Congress, which is reflected in the U.S. Department of Justice's regulations implementing Title III, does not leave health care providers or any other places of public accommodation without recourse. As noted by the First Circuit in this case, the deference afforded to public health officials under the ADA's "direct threat" standard is not absolute. Petitioner and other defendants, whether health care providers or not, are free to come forward and challenge the views of public health officials "based on contrary, properly supported opinions voiced by other recognized experts in the

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[34] Petitioner's reference to the legislative history statement that "nothing in this legislation is intended to prohibit a physician from providing the most appropriate medical treatment in the physician's judgment," is incomplete and therefore misleading. Pet. Brief at 43, *quoting* S. Rep. No. 101-116, at 63. This sentence goes on to state that the ADA does not prohibit a physician from: "referring an individual with a disability to another physician when the physician would make a referral of an individual *who does not have a disability*." S. Rep. No. 101-116, at 63 (emphasis added). By using such limiting language, Congress made clear that where a health care provider refuses to treat a patient on the basis of her disability and would not have made the same referral to an individual without a disability, a question of discrimination arises. It is undisputed that the reason for rejection here was the Respondent's disability.

field (e.g., research studies published in peer-reviewed journals)." *Abbott*, 107 F.3d at 945. Defendants, for example, may choose to put forth evidence demonstrating that the reports and opinions of public health officials on which a plaintiff relies are out of date, or reflect stereotypes about people with disabilities. The Petitioner's failure to put forth sufficient evidence to rebut the Guidelines of the U.S. Centers for Disease Control and the policy of the American Dental Association, both of which conclude that with use of universal precautions patients with HIV can be treated in dentists' offices without significant risk, *id.* at 948, does not support the application of a weaker standard for health care providers. This demonstrates why the uniform standard intended by Congress is needed.

CONCLUSION

For the foregoing reasons, the judgment of the Appeals Court should be affirmed.

Respectfully submitted,

*Arlene Mayerson, Esquire
Holly Baldwin, Esquire
Disability Rights Education and Defense Fund
2212 Sixth Street
Berkeley, CA 94710
Telephone: (510) 644-2555

Cary LaCheen, Esquire
137 MacDougal Street
New York, NY 10012
Telephone: (212) 998-6674

Counsel of Record

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

—v.—

SIDNEY ABBOTT, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF INFECTIOUS DISEASES SOCIETY OF AMERICA; NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS; ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS; AMERICAN ASSOCIATION OF DENTAL SCHOOLS; COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS; AMERICAN NURSES ASSOCIATION; ASSOCIATION OF NURSES IN AIDS CARE; NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS; AMERICAN PUBLIC HEALTH ASSOCIATION; ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS; JOHN G. BARTLETT, M.D.; JAMES W. CURRAN, M.D., M.P.H.; JOHN C. FLETCHER, PH.D., M. DIV.; JUNE E. OSBORN, M.D.; MERLE A. SANDE, M.D.; BRIAN WISPELWEY, M.S., M.D. AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

Catherine A. Hanssens*
Heather C. Sawyer
Beatrice Dohrn
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, Suite 1500
New York, New York 10005-3904
(212) 809-8585

Daniel Bruner
Elizabeth A. Seaton
Laura M. Flegel
WHITMAN-WALKER CLINC LEGAL SERVICES DEPARTMENT
1407 S Street, N.W.
Washington, DC 20009
(202) 797-3527

**Counsel of Record*

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INTEREST OF THE *AMICUS CURIAE*

This *amicus curiae* brief is submitted by the Infectious Diseases Society of America; National Alliance of State and Territorial AIDS Directors; Association of State and Territorial Dental Directors; American Association of Dental Schools; Council of State and Territorial Epidemiologists; American Nurses Association; Association of Nurses in AIDS Care; National Association of Public Hospitals and Health Systems; American Public Health Association; Association of Reproductive Health Professionals; John G. Bartlett, M.D.; James W. Curran, M.D., M.P.H.; John C. Fletcher, Ph.D., M. Div.; June E. Osborn, M.D.; Merle A. Sande, M.D.; Brian Wispelwey, M.S., M.D. ("Medical, Dental, Nursing and Public Health Professionals").[1] Medical, Dental, Nursing and Public Health Professionals play central roles in treating people with Human Immunodeficiency Virus ("HIV") disease and in protecting the public from the further spread of HIV and Acquired Immune Deficiency Syndrome ("AIDS"). The statements of interest of *amici* are included in the appendix to this brief.

This Court's rulings on the scope of the protections provided for those infected with HIV by the Americans with Disabilities Act ("ADA") will have a profound effect not only on individuals living with the virus, but also on public health efforts to combat the HIV epidemic. Medical, Dental, Nursing and Public Health Professionals have a central interest in ensuring that the Court understands the nature of HIV disease; how the virus is transmitted; and the threat which HIV discrimination, and the erosion of laws

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[1] This brief has been authored in its entirety by undersigned counsel for the *amici*. No person or entity, other than the named *amici* and their counsel, made any monetary contribution to the preparation or submission of this brief.

prohibiting it, pose to the public health as well as to the health of those infected with the virus.

By written consent of the parties,[2] *amici curiae* Medical, Dental, Nursing and Public Health Professionals submit this brief in support of Respondent Sidney Abbott.

SUMMARY OF ARGUMENT

The ADA prohibits discrimination against any individual with "a physical or mental impairment that substantially limits one or more of the major life activities of such individual." 42 U.S.C. § 12102(2) (1996). Infection with HIV meets this statutory definition.

HIV infection indisputably is an impairment. There is no period of time when the virus remains latent, and from the point of infection, HIV ravages the immune system and the ability to avoid disease. HIV also substantially limits major life activities of virtually every infected person. HIV is transmissible from infection until death, a fact which necessarily has a profound effect on human intimacy and procreative activities and which feeds the irrational fear and discrimination which confronts people who are infected.

A ruling by this Court that the ADA does not cover all persons with HIV infection would seriously undermine the nation's fight against the epidemic. A decision to deny protection to HIV-infected individuals who are without visible symptoms of disease, or who are unable to prove that they would have a child if uninfected, would be a powerful disincentive to get tested, seek medical attention, and secure the knowledge necessary to avoid infecting others. The pattern of discrimination against persons with HIV demonstrates that the unfounded fear of infection, not the

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[2] Letters of consent from all parties have been filed separately with the Clerk of the Court.

stage of disease, fosters discrimination; denial of protection for those in the earlier stages of HIV will legitimize, and likely increase, the too prevalent pattern of medical providers' refusals to treat those in need of care.

The argument that an HIV-infected patient poses a direct threat of infecting a dentist is completely at odds with scientific and medical knowledge. The risk of transmission of HIV in dental care is negligible, and all but eliminated by the consistent use of universal precautions which have been recommended by the Centers for Disease Control and Prevention and required by the Occupational Safety and Health Administration since the 1980's.

Judicial deference to the judgment of Petitioner, or any individual health care professional who refuses to treat patients with HIV because of concern that he might become infected, is unwarranted and in conflict with professional standards which treat such behavior as unethical. Deference to the unsupported opinion of an individual physician, dentist or other health care professional, rather than to the overwhelming consensus of public health officials charged with control of an epidemic, would jeopardize the public health and hinge the medical care access of those with HIV on the willingness of providers to overcome the irrational fear of a stigmatized disease.

ARGUMENT

I. FROM THE ONSET OF INFECTION, HIV IS A SERIOUS MEDICAL IMPAIRMENT.

HIV infection is a medical impairment. It always causes "loss or abnormality of psychological, physiological or anatomical structure or function." *Stedman's Concise Medical Dictionary for the Health Professions* 434 (3d ed. 1997). It is a remarkably complex retrovirus with a

"profound pathogenicity," i.e., ability to cause disease. Warner C. Greene, *Molecular Insights Into HIV-1 Infection,* in The Medical Management of AIDS 17, (Merle A. Sande & Paul A. Volberding eds., 5th ed. 1997). While the description of the earliest stage of HIV disease as "asymptomatic" is established in medical parlance, it is a construct to describe this stage rather than a medical reality.

From the outset, the virus targets those "T cells" (CD4+ helper T cell lymphocytes) which activate and regulate components of the immune system's response. Silvija I. Staprans & Mark B. Feinberg, *Natural History and Immunopathogenesis of HIV-1 Disease,* in The Medical Management of AIDS, *supra,* at 29, (5th ed.). The virus infects T cells, uses the cell's own genes to manufacture new viruses that infect other cells, and destroys increasing numbers of T cells in the process. Greene, *supra*; Staprans & Feinberg, *supra,* at 29. HIV targets those T cells which "may be the most essential in maintaining normal immune function," as well as cells which ingest pathogens and other harmful substances (bacteria, viruses and dead tissue). Staprans & Feinberg, *supra,* at 29. HIV triggers other disease processes not directly linked to immune system collapse, such as wasting (emaciation) and dementia. Department of Health and Human Services, National Institutes of Health, Report of the NIH Panel to Define Principles of Therapy of HIV Infection, at 18, (1997) [hereinafter "1997 NIH Panel Report"]; Greene, *supra,* at 19-20; Staprans & Feinberg, *supra,* at 34.

As noted recently by an expert panel convened by the National Institutes of Health:

> HIV infection is always harmful, and true long-term survival free of clinically significant immune dysfunction is unusual.
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> ***

> ...Only about 2 percent or less of HIV-infected persons seem to be able to contain HIV replication to extremely low levels and maintain stable CD4+ T-cell counts within the normal range for lengthy periods ..., and many of these individuals display laboratory evidence of immune system damage.

1997 NIH Panel Report, *supra,* at 4 (reference omitted).

After the first signs of infection, a person who has tested HIV-positive[3] may be outwardly asymptomatic for years. However, the virus continues to spread throughout the body. "Although a period of clinical latency occurs in most individuals after acute infection, there is clearly not a period of virological or immunological latency." Sharon A. Riddler & John W. Mellors, *HIV-1 Viral Dynamics and Viral Load Measurement: Implications for Therapy*, in AIDS Clinical Review 1997/1998 47, 50 (Paul Volberding & Mark A. Jacobson eds., 1998). Recent studies conclusively demonstrated that the infected person hosts a very high level of continuous "virologic mayhem" -- daily and massive production of HIV virus, matched with massive destruction of T cells and generation of new cells attempting to replace them. Greene, *supra,* at 21; Riddler & Mellors, *supra,* at 49-50.

Even in patients who are in early stages of HIV disease, the virus is causing a wide variety of laboratory abnormalities, including anemia, platelet deficiencies, and other blood deficiencies. Margaret A. Fischl, *An Introduction to the Clinical Spectrum of AIDS,* in Textbook of AIDS

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[3] The commonly-used HIV tests detect antibodies for the virus in the individual's blood. When blood tests are positive for HIV antibodies, the individual has "seroconverted" and is termed HIV seropositive or HIV-positive. John Bartlett, Medical Management of HIV Infection, at 15 (1997 ed.).

Medicine 149, 150 (Samuel Broder et al. eds., 1994). Many patients suffer persistent dermatologic abnormalities, including scabies, psoriasis that is difficult to control, and a variety of bacterial and fungal infections. Michael S. Saag, *Clinical Spectrum of Human Immunodeficiency Virus Diseases,* in AIDS: Etiology, Diagnosis, Treatment and Prevention 203, 206 (Vincent T. DeVita et al. eds., 4th ed. 1997). Moreover, even outwardly asymptomatic patients are at increased risk for a number of potentially very serious medical conditions including mycobacterium tuberculosis, syphilis, acute and chronic hepatitis, toxoplasma gondii, and pneumocystis carinii pneumonia. Fischl, *supra*, at 150-51. In most infected persons, HIV infection progresses to severe immunodeficiency and AIDS[4] -- the "susceptibility to opportunistic infections, malignancies, neurologic diseases, and wasting, eventually leading to death." 1997 NIH Panel Report, *supra*, at 4.

II. FROM THE ONSET OF INFECTION, HIV SUBSTANTIALLY LIMITS A RANGE OF CENTRAL ACTIVITIES IN THE LIVES OF INFECTED INDIVIDUALS.

HIV profoundly alters the lives of those who are infected, forcing them to forego, or alter, several important life activities in a way that is profoundly different from that of persons without HIV-compromised immune systems.

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[4] Under Center for Disease Control and Prevention criteria, AIDS is diagnosed when a patient has one or more of a series of opportunistic infections or other diseases resulting from severe immunodeficiency, or when the patient's T cell count falls below 200 per cubic millimeter of blood (with normal T cell counts in the range of 1000). CDC, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MMWR RR-17 (1992).

Those infected with HIV must contend with the need to take precautions during every sexual encounter, and with the knowledge that the decision to bear a child risks transmission of a typically fatal illness to both the child and the other parent. Many must take medications in difficult regimens with often debilitating side effects. The need for proximity to medical professionals who treat HIV, and the inability to vaccinate against a number of potentially serious illnesses, limits travel and the ability to interact safely with others. The HIV-positive person also must live with chronic concerns about others' knowledge of his or her health status, social stigma and shame, the fear and reality of discrimination, and deep uncertainty about the future. Individually and in combination, these factors make it substantially more difficult for a person with HIV to care for himself and to take part in the full range of interactions with others, including sexual intimacy.

A. HIV Infection Substantially Interferes With The Ability to Care for Oneself.

Appropriate medical management of HIV disease includes all stages of disease, from initial infection through AIDS. Fischl, *supra*, at 149-58. It is important that patients with HIV infection "have their care optimized and disease progression slowed by a combination of monitoring, preventive therapy, and well-timed intervention with antiretroviral agents." Michael Clement & Harry Hollander, *Initial Evaluation of and Health Care Maintenance for the HIV-Infected Adult,* in The Medical Management of AIDS 130, 138 (Merle A. Sande & Paul A. Volberding, eds., 4th ed. 1995).

Physicians counsel patients with HIV infection to set their personal health care as a new priority in their lives. Lynda S. Doll & Beth A. Dillon, *Counseling Persons*

Seropositive for Human Immunodeficiency Virus Infection and Their Families, in AIDS: Etiology, Diagnosis, Treatment and Prevention, *supra*, 533, 534-38. In addition to medications typically prescribed to slow the progression of the disease, a physician will start the patient on prophylactic medications as immune system damage increases to prevent certain kinds of opportunistic infections, even if the patient is still relatively asymptomatic. Clement & Hollander, *supra*, at 109.

In 1996 and 1997, new antiretroviral therapies were approved by the Food and Drug Administration which, at least to date, are proving very effective in controlling disease progression in many patients. *See, e.g.*, Paul A. Volberding, *Protease Inhibitors Vindicated*, 350 Lancet SIII 10 (1997). The two major developments have been the introduction of new drugs, called protease inhibitors; and the adoption of "combination therapy" – the use of several antiretroviral drugs in combination. There are solid scientific reasons to believe that these combination therapies will benefit not only patients with more advanced HIV disease, but also many patients who are outwardly asymptomatic, and this therapy has been recommended for both. 1997 NIH Panel Report, *supra*, at 7; Steven F. Deeks & Paul A. Volberding, *HIV-1 Protease Inhibitors*, in AIDS Clinical Review 1997-1998 145, 174-75 (Paul A. Volberding & Mark A. Jacobson eds., 1998).

While the new therapies have saved lives, even after initiation of treatment the immune system does not completely recover, and significant damage caused by HIV likely is irreversible. Deeks & Volberding, *HIV-1 Protease Inhibitors, supra,* at 174-75. They also are burdensome, require substantial changes in each patient's diet and eating schedule, and typically require some scheduling accommodation in a range of settings, including work. These therapies "require[] strict adherence to complicated dosing regimens," Deeks & Volberding, *supra,* at 147. Because of

the danger of developing drug resistance, patients must strictly comply with the prescribed dosing regimen. 1997 NIH Panel Report, *supra*, at 12. The medications must be taken several times a day, usually at very specific intervals. Deeks & Volberding, *HIV-1 Protease Inhibitors, supra,* at 176. Some pills must be taken with high-calorie meals, some in a fasting state, and at least one requires aggressive hydration to prevent a build-up in the kidney. *Id.* Some of these medications require refrigeration, *id.*, which makes them more difficult to take at work and restricts activities away from home. Many patients find it impossible to comply with such a regimen for the rest of their lives, and as a result multiple drug resistance develops. Volberding, *Protease Inhibitors Vindicated, supra*, at SIII 10; *see* Deeks et al., *HIV-1 Protease Inhibitors*, J.A.M.A. 145, 152 (1997) (questioning whether "patients outside of a monitored research setting [can] comply with complicated regimens").

In addition, the medications commonly produce a number of side effects, sometimes very debilitating. Deeks & Volberding, *HIV-1 Protease Inhibitors, supra*, at 177. The side effects include severe nausea and abdominal pain, diarrhea, fatigue, weakness, anorexia, headaches, taste disturbances, and various laboratory abnormalities. *Id.*

Not only do many patients require some adjustment of work schedules in order to take medications under the prescribed conditions and to adjust to side effects, but the demanding nature of antiretroviral regimens may impose significant restrictions on a patient's ability to travel. HIV-positive persons must consider avoiding locations where there is not ready access to HIV medical expertise, and they cannot be immunized against several potentially deadly diseases.[5]

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[5] Vaccinations using live virus or bacteria are contraindicated for patients with HIV infection. Such vaccines include measles, mumps and rubella (MMR), varicella-zoster, BCG and yellow fever. Bartlett, *supra*

Although the new antiretroviral therapies are an exciting advance in HIV disease management, the virus has not been defeated, nor has HIV been transformed from a fatal to a manageable, chronic illness. Unfortunately, there also are significant numbers of patients for whom the new therapies do not appear to work or who develop resistance to these therapies. Deeks et al., *HIV-1 Protease Inhibitors*, *supra*, at 150-51; Volberding, *Protease Inhibitors Vindicated*, *supra*. Perhaps most important, these medications are too new for physicians to know whether the drugs will be effective in fighting disease progression in the long term. Deeks & Volberding, *HIV-1 Protease Inhibitors*, *supra*, at 179.

HIV threatens more than one's physical health, and many persons newly diagnosed with HIV suffer from severe emotional stress. Doll & Dillon, *supra*, at 534; Bartlett, *supra* n.2, at 213; Paul A. Volberding, *How to Tell Patients They Have HIV Disease*, in The AIDS Knowledge Base 2.6-1, 2.6-2 (P.T. Cohen et al., eds., 2nd ed. 1994). Multiple psychosocial stressors persist through all stages of their illness. Lisa Capaldini, *HIV Disease: Psychosocial Issues and Psychiatric Complications*, in The Medical Management of AIDS, *supra*, at 289, (4th ed.). One medical commentator describes this impact of HIV as follows:

> All patients with HIV disease, regardless of physical health status, face fundamental questions regarding the quality and length of their lives. Specific stressors experienced by HIV-positive people may include prolonged periods of physical discomfort, disability, and dependence, lifestyle disruption, loss of work and reduced socioeconomic status, disruption

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n.2, at 55-60.

> of support networks including family supports, decreased self-esteem, and sustained periods of loss of personal autonomy.

Id. at 296 (reference omitted). The depression and anxiety experienced by persons living with HIV often is exacerbated by medications that themselves cause depression and anxiety. *Id.*, at 296, 305. Medical care providers, including *amici*, who have cared for large numbers of persons with HIV disease frequently have seen the damaging effects of depression and anxiety, social stigma, and experiences of discrimination on their patients' health.

B. HIV Infection Substantially Limits Human Intimacy, Sexual Activity, Procreation and Parenting.

The HIV-positive person faces substantial and irreversible obstacles to all forms of intimacy. Most patients with HIV fear that disclosure of their condition will result in stigmatization, rejection by family, friends and co-workers, and discrimination. Doll & Dillon, *supra*, at 535. Stigmatization and discrimination are such important factors that the individual's primary physician or other health care provider are urged to "ask the patient who else knows of his or her seropositivity and review issues of confidentiality related to landlords, employers, insurance, and health care agencies." Laura A. Worth and Jeffrey H. Burack, *Outpatient Management of HIV Infection*, in The AIDS Knowledge Base 4.3-1, 4.3-19 (2nd ed.). Stigma and discrimination are a significant source of depression and anxiety in many patients, Doll & Dillon, *supra*, at 535, as is others' fear of infection, even through casual contact. The reality of HIV discrimination creates a painful dilemma for many HIV-infected persons. Most are understandably cautious about to

whom they disclose their diagnosis, but disclosure is necessary for the infected person to obtain health care and social support. *Id.* at 534.

A person with HIV lives with the reality that unprotected sex not only endangers his or her partner, but also may subject the patient to increased health risks if he or she is exposed to other diseases particularly dangerous for those with HIV, or contracts a new strain of the virus. Worth & Burack, *supra*, at 4.3-18.

Medical professionals often recommend that an infected person not engage in procreative sexual activity because an HIV-infected woman considering pregnancy and childbirth faces several additional risks. First, there is a significant risk that the virus will be transmitted from mother to child – while the child is in the womb, during labor or delivery, or through breast-feeding. Daniel V. Landers & Maureen T. Shannon, *Management of Pregnant Women With HIV Infection*, in The Medical Management of AIDS, 459, 461 (5th ed.). Even if the mother takes AZT during pregnancy and childbirth, in accord with current recommendations to reduce the possibility of HIV transmission to her child, the risk of transmission to the child is reduced only from approximately 25 percent to approximately eight percent. *Id.* at 462; Bartlett, *supra* n.2, at 68; Ann J. Melvin and Lisa M. Frankel, *Pediatric HIV Disease: New Developments in Treatment and Prevention,* in AIDS Clinical Review 1997/1998, 109, 112-13. Apart from the risk that the child might be infected, there is the real risk that the use of AZT monotherapy will produce drug-resistant virus that reduces the mother's own treatment options and that can be passed on to her newborn. Landers & Shannon, *supra*, at 459-61. Finally, uncertainty about their own life expectancy, and their reduced ability to care for themselves and their children, leads some women to decide not to conceive, or to abort when they learn they are pregnant and are HIV-positive. Doll & Dillon,

supra, at 536.

III. A RULING THAT ASYMPTOMATIC HIV INFECTED PERSONS ARE NOT PROTECTED UNDER THE ADA WOULD UNDERMINE PUBLIC HEALTH GOALS IMBEDDED IN THE ACT, BY DISCOURAGING ASYMPTOMATIC PERSONS FROM BEING TESTED, OBTAINING RISK-REDUCTION COUNSELING, AND OBTAINING ESSENTIAL MEDICAL TREATMENT.

In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), this Court recognized that legal protections against discrimination directed towards those with transmissible illnesses are vital to an effective public health policy in our democracy:

> [B]ecause the [Rehabilitation] Act requires employers to respond rationally to those handicapped by a contagious disease, the Act will assist local health officials by helping remove an important obstacle to preventing the spread of infectious diseases: the individual's reluctance to report his or her condition.

Id. at 286 n.15. This principle is particularly applicable to HIV. Antidiscrimination laws protecting all persons with HIV are critical to the nation's fight against the epidemic.

Voluntary HIV testing and counseling are key to controlling the spread of the disease. People who test HIV-positive routinely are counseled to avoid activities that pose a high risk of infecting others. Doll & Dillon, *supra*, at 536. "The earlier the infected person is detected, the earlier he or she may be advised of [his or her] contagious state and

counseled on how to avoid further transmission of this lethal virus." American Medical Association, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 JAMA 2097, 2102 (1987). Encouraging early awareness of HIV infection thus is critical to protecting public health.

Early detection of HIV disease also is critical to effective treatment. A patient's risk of developing many HIV-related opportunistic infections can be greatly reduced by prophylactic medications. As discussed in Part II.A, *supra*, many infected persons should be receiving antiretroviral therapy before they develop advanced HIV disease, and perhaps as soon as possible after infection.[6]

Fear of discrimination is a significant disincentive to undergo HIV testing and to seek medical care. The pervasive and powerful stigma associated with HIV and AIDS, and the justified fear of encountering discrimination, keep many persons from being tested to learn their HIV status. *The National AIDS Strategy* (Office of National AIDS Policy, Washington, D.C.), 1997, at 10, 23. Physicians, hospitals, public health agencies and community-based HIV/AIDS service organizations frequently encounter individuals who have delayed being tested for HIV, or who have delayed seeking medical treatment, counseling and other support services for months or years, because they fear discrimination.

Prior to enactment of the ADA, medical authorities pointed out the correlation between protections against HIV

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[6] Early medical intervention also is extraordinarily cost-effective, both for patients and for the public which must absorb the costs of care for uninsured, or publicly insured, individuals. "Just a few cents worth of medicine a day can prevent Pneumocystis carinii pneumonia, a disease that has catastrophic health consequences and costs." *Costs High for Failure to Get Treatment for PCP - Pneumocystis Carinii Pneumonia*, AIDS Weekly 10 (June 12, 1995).

discrimination and effective implementation of public health policy. A report of the Institute of Medicine of the National Academy of Sciences found that

> fear of discrimination is a major constraint to the wide public acceptance of many potentially effective public health measures. Public health programs will be most effective if they are accompanied by clear and strict sanctions to prevent unwarranted discrimination against those who are infected with HIV or who are at risk of infection.

Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research: Update* 63 (1988). *See also 1987 AMA Report*, 258 JAMA at 2102 (1987) (American Medical Association report declaring that antidiscrimination laws should cover all HIV-positive persons to encourage HIV counseling and testing.)

In the legislative history of the ADA, Congress likewise observed that eradicating HIV discrimination has a significant public health dimension:

> As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination ... will undermine our efforts to contain the HIV epidemic ....

H.R. Rep. No. 101-485, pt. 2, at 31 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 313 (quoting the 1988 Report of the

President's Commission on the Human Immunodeficiency Virus Epidemic). In testimony to Congress, Admiral James Watkins, Chair of the President's Commission, elaborated:

> HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic....Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services that they need because of discrimination based on a positive HIV antibody test.[7]

Petitioner and his *amici* argue that an HIV-positive person subjected to discrimination has no remedy under the ADA unless he or she has visible symptoms of HIV infection and can prove other substantial impacts in his or her own life. Any disability test excluding some individuals with HIV would create a ruinous incentive for people to avoid testing, counseling, and medical treatment.[8] The significance of

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[7] *Americans with Disabilities Act of 1988: Joint Hearing on S.2345 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources and the Subcomm. on Select Education of the House Comm. on Education and Labor,* 100th Cong. 39-40 (1988) (statement of Adm. James Watkins), *reprinted in 2* House Comm. on Education and Labor, 100th Cong., 2d Sess., *Legislative History of Public Law 101-336, The Americans with Disabilities Act,* at 967-68 (1990).

[8] This reluctance to undergo testing probably would be exacerbated in jurisdictions requiring the reporting to public health authorities of positive HIV tests. Proponents of HIV names reporting base their position on the assumption that all persons testing positive are legally protected from discrimination. *E.g.,* Robert Steinbrook, *Battling*

potential discrimination to a decision to have an HIV test is so well recognized that some states require that individuals considering a test be explicitly informed of the risks of discrimination. *E.g.,*Conn. Gen. Stat. § 19a-582(d) (1997); Md. Regs. Code tit. 10, § 52.08.04 (1997); N.Y. Pub. Health § 2781(1) (Consol. 1997). In addition, as noted above (Part II. A), while antiretroviral therapies are recommended for many outwardly asymptomatic people, the decision to initiate therapy requires people with HIV to weigh the health benefits of treatment against the risk of possible discovery of their condition. Dosing requirements make combination therapy difficult for an employee who fears disclosure of her condition in the workplace, and health insurance claims also can alert the employer to a patient's health status. Once initiating therapy, an employee who varies a prescribed dosing regimen (to avoid revealing that he is on medication) risks developing drug-resistant virus.

Discrimination in health care is particularly damaging to efforts to combat the HIV epidemic. It not only results in denial of specific services, but also creates distrust of health care professions and institutions, and further fosters a reluctance by persons with HIV disease to seek medical care. After all, had Ms. Abbott not known, or volunteered, her HIV infection status, Dr. Bragdon would have filled her cavity, and this case would not now be before the Court. Given the importance of early diagnosis and treatment, and the fact that people with HIV experience discrimination as a consequence of unfounded fears about their infection rather than the stage of their illness, it is illogical and inconsistent with critical public health goals to base the protections against health care

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HIV on Many Fronts, 337 N. Engl. J. Med. 779 (1997); Lawrence Gostin et al., *National HIV Case Reporting for the United States – A Defining Moment in the History of the Epidemic,* 337 N. Engl. J. Med. 1162, 1165 (1997).

discrimination on whether symptoms of HIV disease are visible.

The ability of persons with HIV to rely on adequate dental care is important to maintaining their overall medical and psychological health. *Regular Dental Care Can Have Psychological and Physical Benefits*, AIDS Alert at 1 (Nov., 1993). HIV-positive patients generally have a greater incidence of complications from minor dental problems than those without HIV, and some untreated dental conditions can become sufficiently serious to interfere with health-related necessities of eating and taking medication. Michael Glick, *Intraoral Manifestations Associated With HIV Disease*, in *Dental Management of Patients with HIV* 153, 154-57 (Michael Glick ed., 1994).

The need for reliable quality health care, and the fear that this care will be denied, is a source of considerable anxiety for those who are HIV-positive. *E.g.*, Mauro A. Montoya, *If I Tell You, Will You Treat Me?*, 27 J. Marshall L. Rev. 363 (1994). As observed in a collaborative guide on public health, dental practice and HIV, "HIV-infected persons face sometimes insurmountable barriers...in finding health care providers willing to treat them." *Guide to Public Health Practice: HIV and the Dental Community* (Association of State and Territorial Dental Directors & Association of State and Territorial Health Officials, Washington, D.C.) (March, 1989) (J.A. at 125).

Several studies of dental professionals' attitudes conducted over the last decade suggest that patients' fears of discrimination are not unfounded. For example, in a 1991 study of dental students, 75% said that dentists have an obligation to treat patients with HIV, and 62% said that they would treat them in their own practices although 53% said that they would not treat patients with HIV if they had a choice. Eric S. Solomon, et al., *Issues in the Dental Care Management of Patients with Bloodborne Infectious*

Diseases: An Opinion Survey of Dental School Seniors, 55 J. Dental Educ. 594 (1991); Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 Yale J. on Reg. 1, 11-15 (1996) "*Dental Discrimination*"). Recent surveys still indicate both that a significant number of dentists are unwilling to treat patients who are HIV-positive, and that a significant number of persons with HIV encounter dental professionals who are unwilling to treat them. Burris, *Dental Discrimination*, *supra*, at 11-20.[9]

IV. THE RISK OF HIV INFECTION THROUGH DENTAL OR MEDICAL CARE IS

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[9] Lingering fears of patients with HIV, and consequent discrimination, has not been restricted to the dental profession. A survey of 951 neonatologists nation-wide found that many would withhold costly medical treatments from babies born to HIV-positive mothers, even if they had no idea whether the baby actually was infected with HIV. *In Brief...HIV Babies*, 10 AIDS Policy & Law 12 (1995). In the same study, a substantial number of doctors said that they would withhold life-saving treatment of babies even without confirmation of their actual serostatus. Only 25% stated that they would provide such care to babies known to be HIV infected. *Id.* Another survey of health professionals treating critically ill newborns at six New York City hospitals found that a significant number of those polled would be less likely to recommend aggressive treatment of a seriously ill infant with HIV than they would for a critically ill infant with no evidence of HIV exposure. Betty W. Levin et al., *Treatment Choices for Infants in the Neonatal Intensive Care Unit at Risk for AIDS*, 265 J.A.M.A. 2976, 2976-80 (1991). *See also* Ferdinand Christian, Jr. et al., *Open-Heart Surgery in an HIV-Positive Patient*, 10 AIDS Patient Care and STDs 210, 211 (1996) (discussing "a reluctance among surgeons and especially cardiothoracic surgeons to operate on HIV-positive patients"); C. Lewis & M.D. Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected with HIV*, 156 Western J. Med. 36 (1992) (almost half of those physicians surveyed reported an unwillingness to treat HIV-positive patients).

NEGLIGIBLE AND DOES NOT JUSTIFY A REFUSAL TO TREAT A PATIENT WITH HIV DISEASE.

The vehicles of HIV transmission have been well established since the mid-1980's: blood and blood products, semen, cervical and vaginal secretions, and breast milk. Staprans & Feinberg, *supra*, at 29. *See* Bartlett, *supra* n.2, at 2-3, 9-11 (giving breakdown of transmission routes). Dental workers face virtually no risk of acquiring HIV through occupational exposure to these bodily fluids. Despite the millions of dental procedures that have been performed since the first reported case of AIDS in 1981, there has been no documented case of occupational transmission of HIV to a dental worker. CDC, *Occupational Exposure to HIV, Information for Health-Care Workers* (visited January 25, 1998) <http://www.cdc.gov/ncidod/hip/faq.htm; Sara Babich, D.D.S. & Ronald P. Burakoff, D.M.D., *Occupational Hazards of Dentistry*, New York State Dental Journal 27, October 1997, at 26, 27.[10] Since the mid-1980's, seroprevalence surveys of dentists in selected cities and at American Dental Association annual meetings, and seroprevalence studies of dental assistants and dental hygienists in selected cities, have documented HIV infection rates of zero or almost zero. Ruthanne Marcus & David M.

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[10] *See also*, *Facts About AIDS for the Dental Team* (Council on Dental Therapeutics, American Dental Association, Chicago, Illinois), October 1988, at 5-6 *citing* N.M. Flynn et al., *Absence of Antibody Among Dental Professionals Exposed to Infected Patients*, 146 West. J. Med. 439 (1987) (255 dental workers with frequent HIV-positive patients, none HIV-positive), and Robert S. Klein et al., *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 N.Eng.J.Med. 86, 88 (1988)(1,309 dental workers, many practicing in areas with high prevalence of HIV infection, only one dentist tested positive but no occupational exposure to HIV could be documented).

Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers,* in AIDS: Etiology, Diagnosis, Treatment and Prevention, *supra,* at 645, 647-48.

Dentists, like other health care providers, are required to adhere to universal precautions for all patients to avoid exposure to bloodborne pathogens. The term "universal precautions" refers to a set of infection control practices under which health care workers assume that all blood and certain body fluids are potentially infectious and thus always take precautions to prevent direct exposure to these fluids. Universal precautions include basic barrier techniques (i.e. protective attire such as gloves, eyewear, masks, and gowns), careful handling of sharp instruments, safe disposal of all "sharps," use of surface disinfectants, and autoclaving or other methods of sterilizing instruments. Chris H. Miller, *Infection Control*, 40 Dental Clinics of North America 437, 439-54 (1996); CDC, *Recommended Infection-Control Practices for Dentistry*, 35 MMWR 237, 238-41 (1986); CDC, *Recommended Infection-Control Practices for Dentistry,* 1993 42 MMWR RR-8, 1, 3-9 (1993); OSHA, 29 C.F.R. § 1910.1030(d) (1997)(effective March 6, 1992). This is necessary because it is impossible to identify all patients who may be infectious. *See* Charles E. Barr, *Practical Considerations in the Treatment of the HIV-Infected Patient*, 38 Dental Clinics of North America 404, 420 (1994). Universal precautions can be easily and effectively implemented in the dental office.[11]

It is, therefore, inaccurate and misleading for *amicus*

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[11] A decade ago, the American Dental Association noted that patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. *Facts about AIDS for the Dental Team*, *supra* n.10, at 15. It has reiterated this position to this Court. (Brf. *Amicus Curiae* American Dental Association in Supp. of Pet'r at 1-2 n.2.)

Promina to state that a 0.3% risk that a doctor or dentist caring for an HIV-positive patient will contract HIV. (Bragdon *Amicus Curiae* of Promina Northwest Health System in Supp. Of Pet's at 12-13.) The statistic Promina selected is: the risk of actual transmission to infected blood following percutaneous exposure (e.g., through accidental needlestick or laceration of the skin by another sharp object). Ruthanne Marcus & David M. Bell, *Occupational Risk, supra,* 645, 648; Barbara F. Gooch et al., *Percutaneous Exposures to HIV-Infected Blood Among Dental Workers Enrolled in the CDC Needlestick Study*, 126 J. Am. Dent. Ass'n 1237 (1997). In other words, there is a 99.7% probability that the unlikely occurrence of a needlestick or puncture wound, which delivers HIV-infected blood into the body, will *not* lead to infection. CDC, *Occupational Exposure to HIV, supra*. The overall risk faced by any doctor or dentist is very much smaller than 0.3%, since most health care providers never experience percutaneous injuries involving HIV-infected blood. Moreover, the estimated 0.3% risk *if* a health care worker suffers a needlestick or other puncture wound exposing him or her to HIV-infected blood is based on studies of all health care workers. The risk posed by a percutaneous injury to a dentist or other dental professional is much much smaller, and involve extremely small quantities of blood and minor injuries to the dental worker. Gooch, *supra,* at 1239-40.

Because universal precautions clearly work, the CDC unequivocally has stated that health care workers should not deny treatment to HIV-positive patients. CDC, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MMWR 2S, 15S (1987). Petitioner thus defies both well-established scientific evidence, and the findings and recommendations of our nation's leading public health officials, when he contends that dental care of an HIV-positive patient poses any significant risk to him.

V. THE ADA DOES NOT CONTEMPLATE JUDICIAL DEFERENCE TO A HEALTH CARE PROVIDER'S PERSONAL OPINION, UNSUBSTANTIATED BY OBJECTIVE EVIDENCE, THAT AN HIV-POSITIVE PATIENT IS UNSAFE TO TREAT.

Petitioner in effect seeks an exemption from his burden under the ADA to document the existence of a direct threat because of his professional status as a dentist. *Amicus curiae* Promina Northwest Health System similarly argues that "[h]ealth care service providers are unique and deserve special protection under the ADA." (Brf. *Amicus Curiae* of Promina Northwest Health System at 2.) Such an extraordinary level of deference to a defendant who has refused treatment on the basis of a patient's HIV status is inconsistent with the statute, with this Court's decision in *Arline*, and with the ethical standards of the dental and medical professions. There is no particular profession or level of training that automatically immunizes an individual from the prejudices that have long haunted the disabled and particularly those with infectious diseases, such as the plaintiff in *Arline* and the Respondent in this case.

Title III of the ADA covers, among many other types of public accommodations, "a...professional office of a health care provider [or] hospital." 42 U.S.C. § 12181 (7) (A). Nothing in the statute -- or this case -- requires that a health care institution or provider modify professional standards which govern their services. No health care professional is required to provide a patient with care that is medically inappropriate, outside the scope of the practitioner's area of competence, or that the practitioner would not provide to a patient without HIV.

However, when a provider denies services to a person with HIV because of fear of the risk posed by the person to

the provider or others, a single test for determining the legitimacy of the refusal applies to medical and non-medical providers alike. A "direct threat" exists if and only if the defendant proves "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures or by the provision of auxiliary aids or services." 42 U.S.C. § 12182(b)(3)(1996). This is an objective test; a finding of "direct threat" must be "based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence..." 28 C.F.R. § 36.208(c)(1997)(Department of Justice regulations). "Sources for medical knowledge include guidance from public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health, including the National Institute of Mental Health." *Id.* at, App.B. § 6.208(c). *Amici* concur with the court below that "properly supported opinions voiced by other recognized experts in the field (e.g., research studies published in peer-reviewed journals)" also are relevant. *Abbott v. Bragdon*, 107 F.3d 934, 945 (1st Cir. 1997).

The ADA's direct threat test, and the Justice Department's regulations, are based on this Court's rulings in *Arline*. After noting that persons with contagious diseases frequently have suffered from irrational fear and misapprehension, 480 U.S. at 284, the Court declared that, in adopting the Rehabilitation Act, Congress intended "to replace such reflexive reactions...with actions based on reasoned and medically sound judgment." *Id.* at 285. If "those accused of being contagious...never have the opportunity to have their condition evaluated in light of medical evidence...they would be vulnerable to discrimination on the basis of mythology -- precisely the type of injury Congress sought to avoid." *Id.* (footnote omitted). Therefore "courts normally should defer to the reasonable medical judgments of public health officials." *Id.* at 288 (footnote

omitted). This reasoning is entirely applicable to the Petitioner's reflexive reaction to HIV in this case, and particularly appropriate when the risk assessment involves possible transmission of contagious diseases -- both the area of expertise and the special responsibility of officials charged with protection of the public health. Nowhere in *Arline* does this Court suggest that deference is due to a doctor who is a defendant in a case challenging the discriminatory refusal to provide medical care, and who has a clear personal interest in the outcome of the litigation.

Since *Arline*, a number of lower federal courts have addressed cases of discrimination by health care professionals against persons with HIV or other disabilities. Those cases have recognized the need to distinguish bona fide medical opinion from pretext masquerading as medical judgment. In *Sumes v. Andres*, 938 F.Supp. 9 (D.D.C.1996), for example, an obstetrician refused to treat a hearing impaired pregnant woman with a fever, arguing that she was "high risk" and that he was not qualified to treat deaf people. The court held that "a provider may not withhold medical benefits solely based on a participant's disability, but may act only pursuant to a bona fide medical reason." *Id.* at 11.

Similarly, in a case challenging the denial of an ear operation for an HIV-positive patient, the court in *Glanz v. Vernick*, 756 F.Supp. 632, 638 (D.Mass. 1991) found that a rule affording initial deference to a defendant doctor's judgment in such circumstances would "enable doctors to offer merely pretextual medical opinions to cover up their discriminatory decisions." In *Howe v. Hull*, 873 F.Supp 72 (N.D. Ohio 1994), a man with AIDS sought emergency care at a local hospital, but the attending physician refused to admit him, claiming a suspicion that the plaintiff had a rare medical condition that they were not equipped to treat; the court found that this explanation was a pretext.

The claims of Petitioner and *amicus* Promina

Northwest Health System that health care professionals should be able to make their own decisions about risk, without following expert knowledge, are inconsistent with the nature of the dental and medical professions. A health care professional necessarily assumes a small degree of personal risk, *see* 107 F.3d at 948 ("a service provider like Dr. Bragdon is not entitled to demand absolute safety"), and dental and medical ethics recognize both that refusing care to HIV-positive patients is unethical, and that treatment of patients with HIV is not particularly risky:

> Since 1988, the Association has taken the specific position that refusal to treat a patient because that patient has or may have an infectious disease such as AIDS is unethical ... Education on universal precautions and barrier techniques is the most effective means to dispel unwarranted fears among health care professional and the public.[12]
>
> ***
>
> A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.[13]

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[12] *Position Paper on Acquired Immune Deficiency Syndrome* (American Association of Oral and Maxillofacial Surgeons, Rosemont, Illinois), Sept. 1991 (J.A. 111).

[13] *Code of Medical Ethics* (American Medical Association, Chicago, Illinois), 1996-1997 ed., § 9.131 (first issued in 1992). The AMA's Principles of Medical Ethics state that "when an epidemic prevails, a physician must continue his labors without regard to the risk to

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> Dental Health care workers have an ethical obligation to provide dental care to HIV-infected individuals, or those perceived to be at risk of HIV infection, in the same manner as they would to other patients . . . . HIV seropositivity is not sufficient cause for referral.[14]

It appears, however, that some health care providers equate prohibitions against discriminatory denial of care with an attempt of government to impose an affirmative obligation on providers to treat everyone who crosses their office threshold. As a committee of dental professionals observed in a practitioners' guide to AIDS & Dentistry:

> Some dentists are confused about the meaning of non-discrimination when it comes to the provision of dental care. It does not mean that the private practitioner has no choice regarding whom he or she chooses to treat. It does mean that there are some conditions upon which a practitioner may not base his or her treatment decisions.
>
> Dentists retain the right to refuse to take patients for a wide variety of reasons. Civil rights laws, however,

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his own health." *Ethical issues Involved in the Growing AIDS Crisis* (Council on Ethical and Judicial Affairs of the American Medical Association, Chicago, Illinois), Sept. 1988, at 1-2 *citing Principles of Medical Ethics* (American Medical Association, Chicago, Illinois), 1955.

[14] *Guide to Public Health Practice: HIV and the Dental Community* (Association of State and Territorial Dental Directors & Association of State and Territorial Health Officials, Washington, D.C.) (J.A. at 125-26).

> prohibit grounding that refusal upon the prospective patient's belonging to certain groups. No practitioner today would quarrel with the idea that it would be unethical as well as illegal to refuse to treat all blacks or all women. Similarly, AIDS civil rights law, specifically, and physical handicap rights laws, generally, prohibit practitioners from basing their care decisions upon the fear and prejudice which can be associated with physical handicaps, particularly contagious diseases.[15]

As noted in testimony on behalf of the American Dental Association to the President's Commission on the HIV epidemic on the issue of HIV-positive individuals' access to treatment:

> For the dental profession to respond in such a manner that "obligations to self-interest" override obligations to patients would be the beginning of the erosion of professional ethics and the trust that society has placed in the health professions. This trust is given legal sanction through the conferring of licenses to practice dentistry and moral sanction through the conferring of elevated status which dental and medical professionals enjoy in the community by reason of their special knowledge, skills and expertise.

Vincent C. Rogers, D.D.S., M.P.H., Testimony for the American Dental Association to The President's Commission

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[15] *AIDS & Dentistry, A Discussion Leader's Guide*, (Dental Steering Committee, AIDS Education and Training Center for Southern CA, Los Angeles, California) 1991 at 28.

on the HIV Epidemic (Jan. 14, 1988) at 5.[16]

Clearly then, while it is the opinion of *amici* here that the majority of health care workers respond professionally and skillfully in their treatment of HIV-positive patients, the provision of care to such patients, and interpretation of the ADA, cannot rest on the assumption that there will be sufficient accessible providers with "[c]ourage, conscience and calling," as Petitioner Bragdon's *amicus* Promina suggests (Br. *Amicus Curiae* of Promina Northwest Health System at 14), to allow care of the HIV-positive patient to remain the option of the individual provider. If one dentist or health care worker can deny treatment on "professional judgment" about risk of infection that runs counter to the overwhelming consensus of public health authorities, other medical experts, and professional ethical standards, then logically all may do so. A ruling that accommodates such judgments would virtually ensure that fewer health care providers will shoulder an increasing caseload of HIV-positive patients, and that significant numbers of men, women and children with HIV will forego the early medical intervention that reflects the standard of care necessary to

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[16] Indeed, in its *amicus* brief to this Court, the American Dental Association notes that its own ethical policies provide that "a decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive based solely on that fact, is unethical," and that "in Association communications on this issue, members be reminded that a patient's HIV/AIDS status is not a justification for refusal of treatment." *Amicus Curiae* Brief of the American Dental Association at 1-2 n.2. The American Dental Association argues, nonetheless, that the ADA should be interpreted not to cover all HIV-positive persons. Such an interpretation not only would be incorrect and harmful to the public health, but also would provide little if any meaningful guidance for dentists or other health care workers, who would be left not knowing when the ADA and similar laws govern their conduct and when they do not.

preserve health and stem further transmission.

Finally, creation of a "health care professional's exception" to the ADA in determining whether a particular patient poses a direct threat to the provider will have ramifications that extend beyond the health care needs of the affected individual patient. If a dentist or other health care provider is permitted to refuse treatment to persons with HIV or other infectious disease based on the provider's exaggerated fear of infection, communicable diseases of significant threat to the general public will go untreated and will pose an unnecessarily increased risk to the public.

CONCLUSION

For the reasons stated above, the Medical, Dental, Nursing and Public Health Professionals who have joined in this *amicus* brief respectfully submit that the decision below should be affirmed.

Respectfully submitted,

Catherine A. Hanssens*
Heather C. Sawyer
Beatrice Dohrn
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, Suite 1500
New York, NY 10005-3904
(212) 809-8585
* *Counsel of Record*

Daniel Bruner
Elizabeth A. Seaton
Laura M. Flegel
WHITMAN-WALKER CLINIC LEGAL SERVICES DEPARTMENT
1407 S Street, N.W.
Washington, DC 20009
(202) 797-3527

Attorneys for Amici Curiae

Dated: February 6, 1998

APPENDIX

APPENDIX

The Infectious Diseases Society of America represents over 5,000 physicians, scientists and other health professionals dedicated to excellence in patient care, research and public health disease prevention and education in the field of infectious diseases. Infectious diseases is a board certified subspecialty of internal medicine and pediatrics. The majority of persons with AIDS in this country receive care from infectious diseases physicians.

The National Alliance of State and Territorial AIDS Directors (NASTAD) is the only national public health organization in the United States that focuses exclusively on the HIV/AIDS epidemic. Founded in 1992, the organization represents the chief HIV/AIDS program administrators in each state and territorial health departments who are responsible for managing federally-funded and state-funded HIV/AIDS prevention, health care and housing programs in every state. NASTAD members administer HIV prevention and surveillance programs funded by the Centers for Disease Control and Prevention. The organization's members also are responsible for administering programs which serve the medical care, AIDS drug assistance and supportive service needs of a significant number of the low-income, uninsured individuals with HIV/AIDS in the nation. NASTAD believes that discrimination against individuals with HIV infection represents a serious barrier to achieving federal, state and local goals in reducing the spread of HIV and in providing compassionate and effective health care services to individuals who are HIV-infected. As an organization, and as a collection of public health professionals focused on preventing the occurrence of HIV and providing health services to those who are infected, NASTAD is deeply concerned about the very real threat to the public's health

posed by discrimination against individuals with HIV infection.

The Association of State and Territorial Dental Directors (ASTDD) is a non-profit volunteer organization formed as an affiliate of the Association of State and Territorial Health Officers in 1948. ASTDD membership consists of the Chief Dental Public Health Officer of the State Health Department or equivalent public health agency, of the states, territories, or possessions of the United States. The purpose of this association is to consider policies and recommendations of public or private agencies pertaining to the practice of dental public health, which may impact the administration of dental public health programs at the state level, and to adopt policies for the guidance of its members. The ASTDD endorses the recommendations of the U.S. Public Health Service, the Centers for Disease Control and Prevention, and the Code of Ethics of the American Dental Association with respect to the treatment of HIV-positive patients in the private dental office.

American Association of Dental Schools (AADS) represents all 55 dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted. AADS is the only national organization that speaks exclusively for dental education.

Council of State and Territorial Epidemiologists (CSTE) is a professional association of 400 epidemiologists in U.S. states and territories working together to detect, prevent, and control conditions of public health significance. CSTE supports treatment by medical providers of HIV

infected persons and believes that routine dental care should not be denied to such patients. Universal precautions employed consistently are known to protect patients and health care workers, including dentists, form transmission of HIV. CSTE advocates that the public health interest is best served by intolerance of discriminatory refusals to treat HIV infected persons.

The American Nurses Association (ANA), a national labor and professional organization for registered nurses, consists of 53 state and territorial constituent organizations with approximately 180,000 members. The issue before this court directly involves not only the protection of individuals who are HIV-positive under the Americans with Disabilities Act (ADA) but has significant ramifications for the provision of early intervention and treatment of HIV. AMA has been at the forefront in advocating for the protection of patient confidentiality and in assuring all individuals full access to health care treatment.

Association of Nurses in AIDS Care (ANAC) is a national nursing organization committed to the individual and collective professional development of nurses involved in the delivery of care to persons infected or affected by the human immunodeficiency virus (HIV), and to promoting the health, welfare, and rights of all HIV-infected persons. ANAC recognizes that it is a moral, legal, and professional responsibility of nurses to care for persons with HIV infection.

National Association of Public Hospitals and Health Systems (NAPH) represents over 100 metropolitan area safety net hospitals and health systems nationwide. NAPH member institutions serve a large proportion of the nation's HIV/AIDS populations in both inpatient and outpatient

settings. In addition to providing medical care to persons with HIV and AIDS, NAPH has historically supported and advocated for the rights of these persons.

American Public Health Association (APHA) is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialties in public health. APHA also publishes a technical report series dealing with various aspects of the HIV epidemic through the American Journal of Public Health, as well as numerous books related to HIV and state-of-the-art research.

Association of Reproductive Health Professionals (ARHP) is an interdisciplinary medical professional association composed of obstetricians/gynecologists and other physicians, advanced practice clinicians, researchers, educators, and other professionals in reproductive health. ARHP, founded in 1963, has an organizational mission to educate health care professionals and the public on family planning, contraception and other reproductive health issues including sexually transmitted diseases, HIV/AIDS, urogenital disorders, abortion, menopause, cancer prevention/detection, sexual health, and infertility. ARHP opposes restricting the ADA's anti-discrimination protections to those diagnosed with AIDS, and supports the principle that patient care should be a health care provider's primary concern.

John G. Bartlett, M.D., is Professor of Medicine and Chief of the Division of Infectious Diseases at the Johns Hopkins University School of Medicine in Baltimore, Maryland. Dr. Bartlett has authored over 600 medical articles

or chapters and eleven books including the principal physician handbook, Medical Management of HIV (in several editions, most recently 1997). Prior to joining the faculty at John Hopkins, Dr. Bartlett was a professor at the University of California and Tufts University School of Medicine.

James W. Curran, M.D., M.P.H., is Professor of Epidemiology and Dean of the Rollins School of Public Health of Emory University. Dr. Curran was the Coordinator for the Task Force on Kaposi's sarcoma (an AIDS-related cancer) beginning in 1981 and continued as a leader at the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Division until 1995. He currently serves as the CDC liaison for the Association of Schools of Public Health, and chairs the Social Factors Reference subcommittee of the American Public Health Association Policy Committee.

John C. Fletcher, Ph.D., M. Div., was Emily Davie and Joseph S. Kornfeld Professor of Biomedical Ethics at the School of Medicine, and Director of the Center for Biomedical Ethics, University of Virginia, from 1987 until 1997. He also served as the Hospital Ethicist at the University of Virginia Health Services Center. Dr. Fletcher was Chief of the Bioethics Program at the Warren G. Magnuson Clinic Center, National institutes of Health, from 1977 to 1987. Dr. Fletcher has published extensively in medical ethics and bioethics, and is the author, with Dr. Brian Wispelwey, of *AIDS and Ethics* in Textbook of AIDS Medicine (Samuel Broder et al. Eds., 1st ed. 1994, 2d ed. 1998).

June E. Osborn, M.D., a pediatrician and a virologist, is the former Chair of the Congressional National Commission on AIDS (1989 to 1993) and of the World Health Organization's Global Commission on AIDS (1988 to

1992). Now Professor of Emerita at the University of Michigan School of Public health and Medical Schools, Dr. Osborn began working as a medical school faculty member in 1966, and became Dean of the School of Public Health at the University of Michigan from 1984 to 1993.

Merle A. Sande, M.D., holds and is Chairman of the Department of Internal Medicine, The Clarence M. and Ruth N. Birrer Presidential Endowed Chair in Internal Medicine, at the University of Utah. The author of more than 200 scholarly articles, Dr. Sande also is co-editor of the textbook, The Medical Management of AIDS (now in its fifth edition). An infectious disease specialist, Dr. Sande worked as Chief of Medical Services at San Francisco General Hospital when AIDS cases first appeared at the epidemic's beginning in the United States in the early 1980's through 1996.

Brian Wispelwey, M.S., M.D., is an Associate Professor of Internal Medicine (Infectious Diseases), at the University of Virginia in Charlottesville, Virginia, where he serves as the Director of the AIDS and Infectious Diseases Clinic at the University of Virginia Health AIDS Education Program for Health Care Providers, with Dr. Fletcher, Dr. Wispelwey co-authored *AIDS and Ethics* in Textbook of AIDS Medicine.

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In The

Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D., *Petitioner,*

v.

SIDNEY ABBOTT, *ET AL.*, *Respondents.*

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF THE AIDS ACTION COUNCIL, AIDS NATIONAL INTERFAITH NETWORK, AMERICAN ASSOCIATION ON MENTAL RETARDATION, AMERICAN ASSOCIATION OF RETIRED PERSONS, AMERICAN CIVIL LIBERTIES UNION, AMERICAN COUNCIL OF THE BLIND, AMERICAN FOUNDATION FOR AIDS RESEARCH, *ET AL.*, AS *AMICI CURIAE* SUPPORTING RESPONDENTS

[Additional *Amici Curiae* Listed Inside Cover]

Steven R. Shapiro
Jennifer Middleton
Matthew Coles
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street
New York, New York 10004
(212) 549-2600

Of Counsel:
Robert A. Long, Jr.
Alexandra T.V. Edsall
Grail P. Walsh
COVINGTON & BURLING
1201 Pennsylvania Ave., N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

Chai R. Feldblum
Counsel of Record
Associate Professor of Law
Federal Legislation Clinic
GEORGETOWN UNIVERSITY LAW CENTER
600 New Jersey Ave., N.W.
Washington, D.C. 20001
(202) 662-9595

February 1998

Counsel for Amici Curiae

BEST AVAILABLE COPY

ADDITIONAL *AMICI*:

AMERICAN CONGRESS OF COMMUNITY SUPPORTS & EMPLOYMENT SERVICES, AIDS LEGAL REFERRAL PANEL OF THE SAN FRANCISCO BAY AREA, AMERICAN FOUNDATION FOR THE BLIND, AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES, AMERICANS FOR DEMOCRATIC ACTION, INC., AMERICANS WITH DISABILITIES VOTE, THE ARC OF THE UNITED STATES, BAY AREA LAWYERS FOR INDIVIDUAL FREEDOM, BAZELON CENTER FOR MENTAL HEALTH LAW, BLINDED VETERANS ASSOCIATION, CENTER FOR LAW IN THE PUBLIC INTEREST, CENTER FOR WOMEN POLICY STUDIES, CHILDREN AND ADULTS WITH ATTENTION DEFICIT DISORDERS, CITIES ADVOCATING EMERGENCY AIDS RELIEF COALITION, COALITION FOR THE HOMELESS, COMMITTEE FOR CHILDREN, DISABILITY RIGHTS COUNCIL OF GREATER WASHINGTON, EMPLOYMENT LAW CENTER, EVANGELICAL LUTHERAN CHURCH IN AMERICA, GAY AND LESBIAN MEDICAL ASSOCIATION, GAY MEN'S HEALTH CRISIS, HUMAN RIGHTS CAMPAIGN, INTERNATIONAL CONFERENCE ON TRANSGENDER LAW & EMPLOYMENT POLICY, LAWYERS FOR HUMAN RIGHTS, LEARNING DISABILITIES ASSOCIATION OF AMERICA, LEGAL ACTION CENTER, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS, NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS, NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC., NATIONAL CENTER FOR LESBIAN RIGHTS, NATIONAL COUNCIL OF THE CHURCHES OF CHRIST (USA), NATIONAL COUNCIL OF JEWISH WOMEN, INC., NATIONAL EMPLOYMENT LAWYERS ASSOCIATION, NATIONAL GAY AND LESBIAN TASK FORCE, NATIONAL HEALTH LAW PROGRAM, INC., NATIONAL HEMOPHILIA FOUNDATION, NATIONAL LATINO/A LESBIAN AND GAY ORGANIZATION, NATIONAL LESBIAN AND GAY HEALTH ASSOCIATION, NATIONAL LESBIAN AND GAY LAW ASSOCIATION, NATIONAL MINORITY AIDS COUNCIL, NATIONAL MULTIPLE SCLEROSIS SOCIETY, NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER, NATIONAL ORGANIZATION ON DISABILITY, NATIONAL ORGANIZATION FOR RARE DISORDERS, INC., NATIONAL PARENT NETWORK ON DISABILITIES, NATIONAL THERAPEUTIC RECREATION SOCIETY, NEW YORK LAWYERS FOR THE PUBLIC INTEREST, INC., NISH, PROJECT INFORM, RESOLVE, TITLE II COMMUNITY AIDS NETWORK, AND UNION OF AMERICAN HEBREW CONGREGATIONS

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INTEREST OF THE *AMICI CURIAE*

The *amici curiae*[1] joining this brief — AIDS Action Council, AIDS National Interfaith Network, American Association On Mental Retardation, American Association Of Retired Persons, American Civil Liberties Union, American Council Of The Blind, American Foundation For AIDS Research, American Congress Of Community Supports & Employment Services, AIDS Legal Referral Panel Of The San Francisco Bay Area, American Foundation For The Blind, American Network Of Community Options And Resources, Americans For Democratic Action, Inc., Americans With Disabilities Vote, The Arc Of The United States, Bay Area Lawyers For Individual Freedom, Bazelon Center For Mental Health Law, Blinded Veterans Association, Center For Law In The Public Interest, Center For Women Policy Studies, Children And Adults With Attention Deficit Disorders, Cities Advocating Emergency AIDS Relief Coalition, Coalition For The Homeless, Committee For Children, Disability Rights Council Of Greater Washington, Employment Law Center, Evangelical Lutheran Church In America, Gay And Lesbian Medical Association, Gay Men's Health Crisis, Human Rights Campaign, International Conference On Transgender Law & Employment Policy, Lawyers For Human Rights, Learning Disabilities Association Of America, Legal Action Center, National Association Of People With AIDS, National Association Of Protection And Advocacy Systems, National Association Of Social Workers, Inc., National Center For Lesbian Rights, National Council Of The Churches Of Christ (USA), National Council Of Jewish Women, Inc., National

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[1] Counsel for the *amici curiae* authored this brief in its entirety. No person or entity, other than the *amici curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. Letters of consent from all parties have been filed with the Clerk of the Court.

Employment Lawyers Association, National Gay And Lesbian Task Force, National Health Law Program, Inc., National Hemophilia Foundation, National Latino/a Lesbian And Gay Organization, National Lesbian And Gay Health Association, National Lesbian And Gay Law Association, National Minority AIDS Council, National Multiple Sclerosis Society, National Native American AIDS Prevention Center, National Organization On Disability, National Organization For Rare Disorders, Inc., National Parent Network On Disabilities, National Therapeutic Recreation Society, New York Lawyers For The Public Interest, Inc., Nish, Project Inform, RESOLVE, Title II Community AIDS Network, and Union Of American Hebrew Congregations — consist of a range of organizations that represent individuals with disabilities, including HIV infection. A number of the organizations provide direct services and/or advocacy to people with AIDS and HIV infection, a number provide direct services and/or advocacy to people with a range of disabilities, and a number advance the rights of women, youth, older persons, or various ethnic or religious groups. A short description of each of the *amici* appears in the Appendix.

The *amici* share a commitment to eradicating the dehumanizing and debilitating discrimination faced by people with disabilities, many of whom are members of the *amici* organizations. We therefore have a keen interest in the effective implementation of the Americans with Disabilities Act (ADA) through affirmance of the decision below. Moreover, over the past decade, many of the *amici* have worked together to seek congressional passage of legislation addressing the pernicious discrimination faced by people with disabilities, and to oppose efforts to exclude people with HIV from such legislative enactments. Thus, many of us bring to this Court's attention a unique perspective and knowledge of history concerning legislation such as the Civil Rights Restoration Act of 1987, the Fair Housing Amendments Act

of 1988, and, finally, the Americans With Disabilities Act of 1990 — the most important civil rights legislation for people with disabilities. Petitioner offers an interesting, but completely erroneous, account of the political struggle that preceded coverage of people with HIV infection under the ADA. (Pet. Brief at 19-27.) Our organizations were present during the struggle to pass the ADA, and we are acutely aware of how controversial issues were resolved during passage of that law.

Because of the services we provide to people with AIDS and HIV infection and/or people with disabilities generally, and because of the civil rights protection we seek for a range of individuals, *amici* also have a unique understanding of the purpose and role of anti-discrimination laws. We bring to this Court an assessment of how the law can be appropriately implemented to serve its purpose of bringing millions of individuals with disabilities into the mainstream of American life.

SUMMARY OF THE ARGUMENT

Governmental policy towards people with disabilities has evolved during our Nation's history. While people with disabilities were once seen solely as objects of disapproval, pity, or rehabilitation, governmental policy over the past 30 years has reflected a growing commitment to viewing people with disabilities as deserving of a civil right to participate in the mainstream of society.

Under this civil rights model, Congress has established protection for individuals with a range of impairments who experience limitations in society. These limitations may arise directly from physical or mental impairments, or may arise because of societal responses to such impairments. In either case, the definition of "disability" used by Congress has been

precisely drawn to provide civil rights protection to a wide range of individuals with physical and mental impairments — not just to those with "traditional" handicaps.

Because of political realities, Congress has also been forced to confront directly whether people with AIDS and asymptomatic HIV infection should be included in the group of individuals provided civil rights protection. On three separate occasions, Congress had chosen to reaffirm coverage for people with AIDS and HIV infection among the covered group of people with disabilities.

Putting Congressional intent aside, the language used by Congress to define "disability" effectively covers a range of serious physical or mental impairments, including asymptomatic HIV infection. The inherent characteristics of certain impairments eliminate the need for proving, in each individual case, that the impairment limits a particular life activity of that individual. Scientific evidence, and in some cases common sense, tells us that certain impairments almost always substantially limit one or more major life activities. HIV infection falls into such a category. Receiving the news that one is infected with a virus that systematically destroys one's immune defenses from the moment of infection, and will ultimately leave one vulnerable to an untimely death, substantially limits the major life activities of reproduction, sexual intimacy, caring for one's self, interaction with others, and most fundamentally, life itself.

ARGUMENT

I. THE DEFINITION OF DISABILITY UNDER THE AMERICANS WITH DISABILITIES ACT IS INTENTIONALLY BROAD TO ACHIEVE THE CIVIL RIGHTS PURPOSES OF THE LAW.

The Americans with Disabilities Act (ADA) represents a simple yet revolutionary notion: people with disabilities are

part of the mainstream of America, and thus have a civil right to participate in the range of services, benefits, and employment opportunities that make up our society. The definition of a "person with a disability" under the ADA is formulated precisely to achieve inclusion of the full range of individuals who need and deserve such civil rights protection.

Individuals with disabilities who need civil rights protection are not only those who have impairments that give rise directly to specific physical and mental limitations. Rather, many individuals with disabilities are limited because of a complex interplay between the actual limiting aspects of their impairments and the societal limitations that arise because of the responses of others to such impairments. Thus, the definition of "disability" under civil rights laws has been carefully formulated to encompass both sources of limitation.[2]

A civil rights model, with an accompanying broad definition of disability, has not always formed the basis of governmental policy toward people with disabilities. Through much of the 1800s and into the mid-1900s, people with disabilities were seen as useless and dependent, hidden and excluded from society, first in private homes and subsequently in institutions.[3] Governmental policy towards people with disabilities consisted primarily of paying for their care in institutions, and occasionally supporting efforts to reform the institutions. In the late 1800s and early 1900s, the

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[2] In *School Board of Nassau County v. Arline*, 480 U.S. 273, 284-85 (1987), this Court recognized that people with disabilities face dual sources of limitations.

[3] *See* DAVID ROTHMAN, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC xiii (1971); UNITED STATES COMMISSION ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES 17-20 (1983); STANLEY HERR, RIGHTS AND ADVOCACY FOR RETARDED PEOPLE 18-29 (1983).

government tolerated (and even encouraged) a eugenics movement that resulted in the sterilization of hundreds of people with disabilities.[4] Pity, exclusion and shame were the pervasive attitudes toward people with disabilities.

With the return of veterans from the First World War, a governmental policy of vocational rehabilitation for people with disabilities began to supplement the existing approach of pity and exclusion. In 1918, Congress passed the first federal law mandating vocational rehabilitation programs for veterans with disabilities, and two years later, extended such programs to civilians.[5] Over the next fifty years, Congress would continue to expand and support vocational rehabilitation programs for a range of people with disabilities.[6]

The definition of "handicapped individual," which remained virtually unchanged from the Vocational Rehabilitation Act of 1920 until enactment of the Rehabilitation Act of 1973, was tailored to fit the purposes of rehabilitation programs. Thus, a handicapped individual was defined as "any individual who (A) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (B) can reasonably be

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[4] *See* ACCOMMODATING THE SPECTRUM, *supra* note 3, at 19-20; RICHARD SCOTCH, FROM GOOD WILL TO CIVIL RIGHTS: TRANSFORMING FEDERAL DISABILITY POLICY 15-17 (1984). *See also Buck v. Bell*, 274 U.S. 200 (1927).

[5] *See* Vocational Rehabilitation Act, Pub. L. No. 66-11, 41 Stat. 158 (1919); Pub. L. No. 66-236, 41 Stat. 735 (1920).

[6] SCOTCH, *supra* note 4, at 19-24; GARY L. ALBRECHT, THE DISABILITY BUSINESS: REHABILITATION IN AMERICA 102-7 (1992).

expected to benefit in terms of employability from vocational rehabilitation services . . ."[7]

During the 1960s, the modern civil rights movements for African-Americans and for women gathered momentum. These movements were premised on the belief that all individuals deserve to be treated equally and with dignity in our society, regardless of their race, gender or religion.[8] During this time, people with disabilities began to demand more autonomy in their lives, starting an "independent living" movement and rejecting the notion that disability equaled dependence.[9]

People with disabilities were not included in the first wave of civil rights legislation.[10] When Congress reauthorized federal rehabilitation programs in 1973, however, it included a provision prohibiting discrimination against a "qualified handicapped individual" on the part of any program or activity that received federal funds.[11] Realizing that its original definition of "handicapped individual" was too narrow to

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[7] Rehabilitation Act of 1973, Pub. L. No. 93-112, § 7(6), 87 Stat. 355, 361 (1973).

[8] SCOTCH, *supra* note 4, at 24-27.

[9] *Id.* at 34-37; Jonathan C. Drimmer, *Cripples, Overcomers, and Civil Rights: Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities*, 40 UCLA L. Rev. 1375-85 (1993).

[10] *See* Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964); Civil Rights Act of 1968, Pub. L. No. 90-284, 82 Stat. 73 (1968).

[11] Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (1973). *See* SCOTCH, *supra* note 4, at 41-59. This provision is colloquially referred to as "Section 504."

achieve the civil rights goal embodied in Section 504,[12] Congress passed a new definition of "handicapped individual" solely for purposes of Titles IV and V of the Rehabilitation Act:

> [A]ny person who (A) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (B) has a record of such an impairment, or (C) is regarded as having such an impairment.[13]

This new definition of disability reflected Congress' understanding that individuals with a range of physical and mental impairments (and not simply individuals with "traditional" handicaps) often faced discrimination when they sought to participate in society.[14] The definition also recognized that individuals could be "handicapped" either as a result of real physical or mental limitations that flowed from impairments and/or as a result of societal responses to such impairments.[15] Thus, Congress adopted a new, functional definition of handicap — one that extended coverage to individuals based on the range of effects various physical or mental conditions could have on the basic functions of life.

It fell to the Department of Health, Education, and Welfare (HEW) to delineate in regulations how Congress' new functional definition would be applied. HEW's regulations reflected its understanding of the balance Congress had struck

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[12] *See* statutory definition *supra* note 7 and accompanying text.

[13] Rehabilitation Act Amendments of 1974, Pub. L. No. 93-516, § 111, 88 Stat. 1617 (1974).

[14] *See* S. REP. NO. 93-1297, at 16, 37-38, 50 (1974). *See also Arline*, 480 U.S. at 278-79 (recounting Congressional activity).

[15] *Id.* at 284.

in the new definition of "handicap." Recognizing that Congress had chosen to extend civil rights protection to those with "non-traditional" handicaps, HEW offered examples such as epilepsy, cancer, heart disease, diabetes, and emotional illness as conditions that could be covered, assuming they were serious enough to affect an individual's life activities.[16] At the same time, HEW emphasized that the statutory language of the first prong of the definition precluded coverage of trivial medical conditions as disabilities, such as bruised elbows and common colds, because these impairments were not sufficiently serious to limit such individuals' activities on an ongoing basis.[17]

Congress manifested its recognition of the broad scope of the three-prong definition of "handicap" and "disability" as it began to expand civil rights protection for people with disabilities. In the Fair Housing Amendments Act of 1988, Congress took a significant step forward by extending

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[16] 45 C.F.R. § 84.3(j)(2)(i)-(ii) (1977). In response to the recommendation that the definition be narrowed so as to cover solely "traditional" handicaps, HEW responded it had "no flexibility within the statutory definition to limit the term to persons who have those severe, permanent, or progressive conditions that are most commonly regarded as handicaps." 46 Fed. Reg. 22,677 (May 4, 1977), *reprinted in* 45 C.F.R. § 84, App. at 333-34 (1997).

[17] The agency also noted that some impairments that might not seem serious — and, indeed, may not be serious at all — would still be covered under the third prong of the definition of disability based solely on the societal limitations arising from such conditions. *See* statutory definition *supra* note 13 and accompanying text. For example, a large birthmark on a cheek is not a serious physical impairment. Nevertheless, the negative attitudes or responses by others towards that impairment (if they result in discriminatory actions) can create coverage for such an individual. *See* 29 C.F.R. § 1630.2(l) (1996); *Arline*, 480 U.S. at 282. *Amici* do not address coverage under the third prong in the instant case, but agree with the analysis set forth by Respondent. *See* Resp. Brief.

protection for people with disabilities in the sale or rental of private housing.[18] In this law, Congress used the same definition of "handicap" as in Section 504, and contemplated that individuals with a similar range of physical and mental impairments would be protected under the law.[19]

Similarly, when Congress enacted the Americans with Disabilities Act (ADA), it used the same definition set forth in Section 504 — this time defining the term "disability."[20] By this point, courts had afforded the protection of Section 504 to individuals with a wide range of impairments, including heart disease, breast cancer, manic depressive illness, dyslexia, multiple sclerosis, and Crohn's disease.[21] Many of these cases were used by Congress to provide examples of the type of discrimination that would be prohibited under the ADA.[22]

Congress has thus deliberately and consistently employed a broad definition of "disability" for purposes of its civil rights statutes. Narrower statutes designed to provide cash

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[18] Pub. L. No. 100-430, 102 Stat. 1619 (1988). This was the first provision of civil rights protection for people with disabilities outside the scope of recipients of federal funds.

[19] *Id.* § 5(b), 102 Stat. at 1619. *See* H. R. REP. NO. 100-711, at 18 (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2179.

[20] Pub. L. 101-336, § 3(2), 104 Stat. 327, 329 (1990).

[21] *See* ROBERT L. BURGDORF, JR., DISABILITY DISCRIMINATION IN EMPLOYMENT LAW 136-140 (1995) (citing cases).

[22] *See, e.g.*, H.R. REP. NO. 101-485(II), at 65, 71-72 (1990) (citing with approval cases involving dyslexia and HIV infection)).

benefits for those too disabled to work[23] or to establish vocational rehabilitation programs[24] appropriately include definitions of disability narrowly tailored to the purposes of those laws.[25] By contrast, civil rights laws appropriately use an inclusive functional definition of disability. Such a definition is essential if these laws are to achieve their basic goal: ensuring that all individuals with physical or mental disabilities, whether actual, past, or perceived, can participate fully in the mainstream of society.

II. CONGRESS EXPLICITLY REJECTED ATTEMPTS TO EXCLUDE PEOPLE WITH AIDS AND ASYMPTOMATIC HIV INFECTION FROM THE DEFINITION OF DISABILITY.

Although Congress deliberately provided that individuals with a range of physical and mental impairments would receive civil rights protection, specific proposals forced Members of Congress to vote directly on the question of

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[23] *See, e.g.*, Federal Social Security Act, 42 U.S.C. §§ 401-433 (1994); Social Security Act, 42 U.S.C. §§ 1381-1383f (1994).

[24] Rehabilitation Act, 29 U.S.C. §§ 701-718b (1994).

[25] *See, e.g.*, 42 U.S.C. § 1382c(a)(3)(A) (1994) (Social Security disability benefits) ("unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months"); 29 U.S.C. § 706(8)(B) (1994) (Rehabilitation Act) (definition quoted *supra* note 13 and accompanying text). *See generally* Matthew Diller, *Entitlement and Exclusion: The Role of Disability in the Social Welfare System*, 44 UCLA L. REV. 361 (1996).

whether people with AIDS and asymptomatic HIV infection should be entitled to such coverage as well.[26]

The first Congressional effort to exclude people with AIDS and HIV infection came in response to this Court's decision in *School Board of Nassau County v. Arline,* holding that a woman with tuberculosis was covered under Section 504's definition of handicap.[27] A few months after the decision in *Arline*, a Senate committee began consideration of the Civil Rights Restoration Act of 1987, a bill designed to broaden the meaning of "program or activity" under laws such as Section 504.[28] During committee consideration, Senator Gordon Humphrey offered an amendment to exclude individuals with "contagious diseases" from coverage under Section 504.[29] The explicit goal of the amendment was to overturn this Court's decision in *Arline*.[30]

Senator Humphrey's amendment was defeated by a vote of 2-14.[31] Six months later when the full Senate began

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[26] For further detail on the proposals described here, *see generally* Chai R. Feldblum, *Federal Legislation Protecting Civil Rights of People with AIDS*, *in* AIDS AND THE COURTS 327 (Clark C. Abt & Kathleen M. Hardy eds., 1990).

[27] 480 U.S. 273. The implications of the *Arline* case for people with AIDS & HIV infection were widely noted in the media. *See* Aric Press, *A Victory for AIDS Victims*, NEWSWEEK, Mar. 16, 1987, at 33.

[28] Pub. L. No. 100-259, § 2, 102 Stat. 28, 28 (1988). *See* S. REP. NO. 100-64, at 4-7 (1987). In *Grove City College v. Bell*, 465 U.S. 555 (1984), this Court had established a limited definition of the term "program or activity."

[29] S. REP. NO. 100-64, at 27-28, 31.

[30] *Id.* at 28.

[31] *Id.* at 27, 31.

consideration of the bill, Senator Humphrey and Senator Tom Harkin, Chair of the Senate Subcommittee on Disability, had reached a compromise. The two Senators jointly offered an amendment patterned directly on the *Arline* decision and a provision that had been added by Congress a decade previously with regard to drug addicts and alcoholics: individuals with contagious diseases or infections who posed a *direct threat* to others would not be covered under Section 504.[32]

The compromise provision specifically included the term "contagious disease *or infection*." The latter phrase was added to include within the ambit of the provision those who were simply infected with a contagious disease — such as those infected with HIV. Indeed, several Members of Congress specifically noted the inclusion of HIV-infected individuals in the provision in stating their acquiescence to it.[33] Those who *opposed* the bill, as amended, also focused on the fact that both people with AIDS and HIV infection would remain covered under Section 504.[34]

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[32] 134 CONG. REC. 383-84 (1988). *Cf.* 124 CONG. REC. 30,322-33 (1978) (amending definition of handicap for Section 504 with regard to drug addicts and alcoholics).

[33] 134 CONG. REC. 2937-38 (1988) (statement of Rep. Owens); *id.* at 2936-37 (statement of Rep. Weiss); *id.* at 2939 (statement of Rep. Waxman); *id.* at 3043-44 (statement of Rep. Hoyer). Although including this provision was a simple codification of the *Arline* decision, it was a compromise because it added a special statutory provision targeted to people with contagious diseases and infections, within a potentially confusing statutory definition. *See* BURGDORF, *supra* note 21, at 392-398 (noting confusion in court decisions regarding coverage of drug addicts and alcoholics under Section 504).

[34] *See, e.g.*, 134 CONG. REC. 4757 (1988) (statement of Rep. Dannemeyer); *id.* at 4768 (statement of Rep. McEwen).

Shortly after Congress passed the final version of the Civil Rights Restoration Act, it took up the Fair Housing Amendments Act of 1988, which provided civil rights protection for people with disabilities.[35] What followed was an almost identical replay of the debate concerning coverage of people with AIDS and HIV infection. In the House Judiciary Committee, Congressman William Dannemeyer offered an amendment to exclude people with "any infectious, contagious, or communicable disease whether or not such disease causes a physical or mental impairment."[36] As a substitute to that amendment, the Committee added a provision that dwellings need not be made available to an individual "whose tenancy would constitute a direct threat to the health or safety of others."[37]

When the full House of Representatives took up the bill, Congressman Dan Burton offered an amendment providing the term "handicap" does "not include any current infection with the etiologic agent for the acquired immune deficiency syndrome."[38] Congressman Dannemeyer offered an addition to Burton's amendment, providing the term "handicap" would not include "any infectious, contagious, or communicable

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[35] Pub. L. No. 100-430, § 6, 102 Stat. 1619, 1620 (1988). *See* H.R. REP. NO. 100-711, at 18, *reprinted in* 1988 U.S.C.C.A.N. 2173, 2179 (regarding coverage of people with AIDS and HIV infection). *See also id.* at 22 n.55, 22-24, *reprinted in* 1988 U.S.C.C.A.N. at 2183; 134 CONG. REC. 15,667 (1988) (statement of Rep. Schroeder); *id.* at 15,654-55 (statement of Rep. Weiss); *id.* at 15,862 (statement of Rep. Pelosi); *id.* at 16,478 (statement of Rep. Bryant).

[36] H.R. REP. NO. 100-711, at 28 (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2189.

[37] *Id. See* Pub. L. No. 100-430, § 6(a), 102 Stat. 1619, 1620 (codified as 42 U.S.C. § 3604(f)(9) (1994)).

[38] 134 CONG. REC. 16,496-97 (1988).

disease whether or not such disease causes a physical or mental impairment."[39] Congressman Dannemeyer explained these amendments were necessary to ensure landlords would have the freedom to deny housing to individuals infected with HIV.[40]

During the debate on these two amendments, it was apparent to all participants that people with AIDS, *and people* with *asymptomatic HIV infection*, would continue to be covered under the Act if these amendments failed.[41] Indeed, it was precisely the need to protect both people with AIDS and people with asymptomatic HIV infection that spurred Members of Congress to oppose the two amendments.[42] Several Members of Congress referred to a recent Presidential Commission recommendation urging civil rights protection for individuals with symptomatic and asymptomatic HIV infection, and to Vice President George Bush's endorsement

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[39] *Id.* at 16,498.

[40] *Id.* ("The amendment I am now offering . . . will say . . . that we do not [include in] the definition of a handicapped person . . . a person with a contagious disease . . . including the virus for AIDS") (statement of Rep. Dannemeyer).

[41] *Id.* at 16,496-504.

[42] *See., e.g., id.* at 16,500 (statement of Rep. Waxman); *id.* at 16,501 (statement of Rep. Owens).

of that recommendation.[43] Both the Burton and Dannemeyer amendments were rejected by the House of Representatives.[44]

By the time Congress took up consideration of the Americans with Disabilities Act (ADA), it was well aware of the debate surrounding anti-discrimination protection for individuals with both AIDS and asymptomatic HIV infection. Following the precedent that was now established, the ADA introduced in May 1989 included at the outset a "direct threat" provision targeted at individuals with contagious diseases or infections.[45]

Many organizations, including many *amici,* anticipated that as in prior years, an amendment might be offered to exclude people with AIDS and HIV infection from coverage under the ADA. Thus, before the Senate considered the ADA, over 50 organizations, representing AIDS, disability, civil rights, and religious groups, sent letters to every Senator

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[43] *See, e.g., id.* at 16,497 (statement of Rep. Frank); *id.* at 16,498 (statement of Rep. Waxman). *See also* H.R. REP. NO. 101-485(II), at 48 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 330.

[44] 134 CONG. REC. 16,504 (1988) (Dannemeyer amendment rejected by vote of 7-89; Burton amendment rejected by vote of 10-84). Congressman Burton offered an identical amendment on a motion to recommit the bill with instructions; that amendment failed by a vote of 63-334. *Id.* at 16,510.

[45] 135 CONG. REC. 8510 (1989); S. REP. NO. 101-116, at 40 (1989). A year later, during consideration of the ADA by the House Committee on the Judiciary, concerns were raised that individuals with mental disabilities might pose a threat to others. The "direct threat" provision was thus amended by that Committee to apply to any individual with a disability. *See* H.R. REP. NO. 101-485(III), at 34 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 457; 136 CONG. REC. 11451 (1990) (statement of Rep. Fish). This amended provision was included in the final version of the ADA. 42 U.S.C. § 12113(b) (1994).

urging that the ADA continue to protect "people with AIDS and HIV infection."[46]

In fact, no general attack on coverage of people with AIDS and HIV infection materialized on the Senate floor. While some Senators were displeased with the Act's coverage of such individuals,[47] the only individuals excluded from the ADA were those addicted to drugs,[48] transvestites,[49] and a group with selected mental and sexual disorders.[50]

Petitioner's theory that the "politically controversial" issue of covering people with AIDS and HIV infection was resolved through a negotiated agreement to create conflicting legislative history, *see* Pet. Brief at 19-26, is fanciful and without any basis in reality. While there were many complicated, negotiated issues in the ADA,[51] coverage of people with AIDS and asymptomatic HIV infection was not one of them. By this time, most Members of Congress were comfortable

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[46] 135 CONG. REC. 19,869-70 (1989). *See also id.* (71 organizations from the Consortium for Citizens with Disabilities urging no "weakening amendments" to the ADA).

[47] *Id.* at 19,864-67, 19,870 (statements of Sen. Helms criticizing coverage of HIV infection under the Act).

[48] 42 U.S.C. § 12114 (1994).

[49] 42 U.S.C. § 12208 (1994). *See* 135 CONG. REC. 19,864 (1989) (colloquy regarding amendment to exclude transvestites from coverage under the Act).

[50] 42 U.S.C. § 12211(b) (1994). *See* 135 CONG. REC. 19,884-85 (1989).

[51] *See generally* Chai R. Feldblum, *Medical Examinations and Inquiries Under the Americans with Disabilities Act: A View from the Inside*, 64 TEMP. L. REV. 521, 523-31 (1991) (detailing negotiations on the ADA).

with coverage of such individuals, and there was no negotiation regarding coverage of AIDS or HIV infection during the entire Senate consideration of the ADA.[52]

A targeted attack on coverage of individuals with AIDS and HIV infection did occur nine months later, when the House of Representatives considered the ADA. But it was not an attack that resulted in a negotiated settlement to include "express endorsements of the HUD regulations." Pet. Br. 25. Rather, it was a broad attack on all people with AIDS and HIV infection who worked in food handling jobs. An amendment was offered by Congressman Jim Chapman allowing an employer "to refuse to assign . . . any employee with an infectious or communicable disease of public health significance to a job involving food handling. . . ."[53] The debate on the amendment reflected an assumption by all Members that, *absent* this amendment, the ADA would continue to cover *asymptomatic HIV-infected* individuals working in food service jobs.[54]

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[52] In any event, Petitioner's theory of a negotiated compromise makes little sense. There are *no* "handicaps" or "disabilities" listed in the regulations; the only list provided is of impairments. Thus, when Congress wished to indicate that HIV disease (everything from asymptomatic HIV infection to AIDS) was included under the ADA's coverage, the logical place for Congress to have added such a reference was to the list of impairments that already existed in the regulations, together with such conditions as orthopedic, visual and hearing impairments, cancer, and cerebral palsy. To guard against any possible misunderstanding, however, the legislative reports also stated that HIV disease was covered under the first prong of the definition of disability. *See* H.R. REP. NO. 101-485(II), at 52 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 334; S. REP. NO. 101-115, at 22 (1989). *See also* H.R. REP. NO. 101-485(III), at 28 n.18 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 451 n.18.

[53] 136 CONG. REC. 10,911 (1990).

[54] *Id.* at 10,911-17.

Congressman Chapman's amendment passed by a vote of 199-187 in May 1989.[55] During the following two months, many of the *amici* and others engaged in an extensive effort to educate Congress and to lobby for the removal of this provision from the final version of the ADA. As a result of this effort, any Member of Congress who was not previously aware that the ADA, as currently written, covered people with AIDS and asymptomatic HIV infection, was likely to have been made aware of that fact.[56] *Amici* were pleased with the outcome of that effort, as the final provision adopted in the ADA protected employees with AIDS and HIV infection in food handling jobs, just as they were protected in other positions where they pose no "direct threat" to others.[57]

III. CERTAIN SERIOUS MEDICAL CONDITIONS, INCLUDING ASYMPTOMATIC HIV INFECTION, ALWAYS MEET THE STATUTORY DEFINITION OF A "DISABILITY."

The language Congress used to define disability in the ADA effectively covers a range of serious physical and mental impairments, including asymptomatic HIV infection.

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[55] *Id.* at 10,917.

[56] *See id.* at 17,046-53 (reprinting letters opposing Chapman amendment.)

[57] *Id.* at 17,033, 17,058 (requiring Surgeon General to issue list of contagious diseases and infections that could be transmitted through food handling). *See* 56 Fed. Reg. 40,897 (1991) (issuance of list without HIV included.)

A. The Inherent Characteristics of Certain Impairments Eliminate Any Need for Proving the Impairment Limits a Particular Individual's Life Activities.

Individualized assessment is central to the ADA's civil rights protection for people with disabilities. The ADA requires that individuals with disabilities be "qualified" for employment positions — that is, they must be able to perform the job's essential functions.[58] The law also requires that, at times, an individual's disability must affirmatively be taken into account and accommodated so that she or he is able to perform a job or receive a benefit.[59] These statutory requirements necessarily assume that an individualized assessment of the abilities and needs of a person with a disability, within the context of a particular job or benefit at issue, will occur in most cases alleging disability-based discrimination.[60]

Deciding if an individual has a disability also requires some form of individualized assessment. The first prong of the definition of "disability" under the ADA extends coverage to individuals who have an impairment that "substantially limits one or more of the major life activities of such

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[58] 42 U.S.C. § 12111(8) (1994). *See also id.* § 12112(A).

[59] *Id.* § 12112(b)(5); *id.* § 12182(b)(2)(A)(ii)-(iii).

[60] *See* H.R. REP. NO. 101-485(III), at 39 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 462; H.R. REP. NO. 101-485(II), at 62 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 344. Such individualized assessments ultimately benefit both the individual with the disability and the entity covered under the law. *See* Chai R. Feldblum, *Antidiscrimination Requirements of the ADA*, *in* IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT 35, 35-37 (Lawrence O. Gostin & Henry A. Beyer eds., 1993) (describing "otherwise qualified" and "reasonable accommodation" requirements of the ADA).

individual."[61] In every case, therefore, a plaintiff must show he or she has an impairment as the ADA uses that term. But it does not follow that, in every case, an individual who has an impairment must show that such impairment substantially limits his or her own major life activities.

Some impairments will be disabling for some individuals but not for others. For example, fibromyalgia is an impairment that causes muscle pain.[62] In some, the pain is relatively minor. In others, the pain is so severe that walking, writing, bending and even sitting are substantially limited.[63] Individualized assessments of such impairments are necessary to ensure that individuals with such impairments are given the opportunity to prove they have a covered "disability" under the ADA. *See Homeyer v. Stanley Tulchin Assocs.*, 91 F.3d 959, 962 (7th Cir. 1996) (determination of whether chronic, severe allergic rhinitis and sinusitis substantially limits major life activity of breathing must be made on an individualized basis); *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763, 774-45 (E.D. Tex. 1996) (impairments that are not inherently limiting must be considered on a case-by-case basis).[64]

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[61] *See* 42 U.S.C. § 12102(2) (1994). *See also* 29 C.F.R. § 1630.2(g) (1996).

[62] Fibromyalgia is a physical "disorder associated with pain and tenderness of muscle and adjacent connective tissue." Robert C. Griggs, *Muscle Spasms, Cramps and Episodic Contractions*, *in* HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 130, 131-32 (Isselbacher et al., eds., 13th ed. 1994) (HARRISON'S).

[63] Bruce Gilliland, *Relapsing Polychondritis and Miscellaneous Arthritides*, in HARRISON'S at 1706-07.

[64] Several courts have inappropriately framed the individualized assessment in cases of this kind as whether the "impairment constitutes for the particular person a significant barrier to *employment*." *Webb v.*

But it would make no sense to require individuals with other impairments — such as a complete lack of sight or legs that have been amputated — to prove that those impairments interfere with their individual lives. Science and common sense tell us that impairments that deprive an individual of the ability to see or to walk always will substantially interfere with major life activities. Nothing in the language or structure of the ADA requires courts to demand proof of the obvious. Disabilities that always substantially limit major life activities are what the courts mean by "per se" disabilities. *Anderson*, 924 F. Supp. at 774-775.

Applying the statutory definition of disability in this manner appropriately ensures that a significant number of individuals will be eligible for coverage under the ADA without unnecessary evidentiary burdens. Such a result is consistent with the intent of Congress and with the statutory language it employed. If courts are faced with unfounded claims of disability discrimination, such claims should be decided against the plaintiffs on the *merits* of the case, and not through inappropriate exclusion from the protected class.[65]

Garelick Mfg. Co., 94 F.3d 484, 488 (8th Cir. 1996), *quoting Forrisi v. Brown*, 794 F.2d 931, 933 (4th Cir. 1986) (emphasis added). While such an evaluation is appropriate in those rare cases where a plaintiff's impairment substantially limits *solely* the life activity of *working*, it is inappropriate where the impairment limits other life activities like concentrating, bending, or stooping. In such cases, the assessment must focus on those activities, and not on employability in general. *See* 29 C.F.R. § 1630, App. at 340 (1996). *See also Katz v. City Metal Co.*, 87 F.3d 26 (1st Cir. 1996) (correcting district court on this point).

[65] Some courts have responded to unfounded claims of disability discrimination by twisting the definition of disability almost beyond recognition. This has resulted in a body of law at odds with the Section 504 case law on which Congress relied in passing the ADA. *Compare Reynolds v. Brock*, 815 F.2d 571, 574 (9th Cir. 1987) (plaintiff with epilepsy is person with disability under § 504); *Fynes v. Weinberger*, 677

B. HIV Infection Is Always a Disability Under the ADA Because Its Inherent Characteristics Substantially Limit One or More Major Life Activities.

All individuals with asymptomatic HIV infection have a physical impairment[66] that substantially limits one or more of their major life activities. HIV substantially limits

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F. Supp. 315, 321 (E.D. Pa. 1985) (plaintiff with asbestosis is person with disability under § 504); *Bentivegna v. U.S. Dep't of Labor*, 694 F.2d 619, 621 (9th Cir. 1982) (insulin-dependent diabetic is person with disability under § 504); *Pushkin v. Univ. of Colorado*, 658 F.2d 1372, 1376 (10th Cir. 1981) (plaintiff with multiple sclerosis is person with disability under § 504) *with Matczak v. Frankford Candy & Chocolate Co.*, 950 F. Supp. 693, 696 (E.D. Pa. 1997) (plaintiff with epilepsy not person with disability under ADA); *Ellison v. Software Spectrum, Inc.*, 85 F.3d 187, 191 (5th Cir. 1996) (plaintiff with breast cancer not person with disability under ADA); *Kocsis v. Multi-Care Management, Inc.*, 97 F.3d 876, 884 (6th Cir. 1996) (plaintiff with multiple sclerosis not person with disability under ADA); *Schluter v. Industrial Coils, Inc.*, 928 F. Supp. 1437, 1445-46 (W.D. Wis. 1996) (insulin-dependent diabetic not person with disability under ADA). An adverse effect of such rulings is that other plaintiffs with similar disabilities who have colorable claims of discrimination have been denied the ability to seek relief under the ADA. *See, e.g., Robinson v. Global Marine Drilling*, 101 F.3d 35 (5th Cir. 1996) (jury verdict for plaintiff with asbestosis resulting in 50% lung capacity reversed on grounds that asbestosis not a disability under ADA). *See generally* Steven S. Locke, *The Incredible Shrinking Protected Class: Redefining the Scope of Disability Under the Americans with Disabilities Act*, 68 U. COLO. L. REV. 105 (1997); NATIONAL DISABILITY LAW REPORTER, DEFINING "DISABILITY" UNDER THE ADA: 1997 UPDATE ii (1997); James G. Frierson, *Heads You Lose, Tails You Lose: A Disturbing Judicial Trend in Defining Disability*, LAB. L. J., July 1997, 419.

[66] Infection with HIV inflicts chronic damage to immune system cells that circulate in the blood and to lymphoid organs throughout the body. NATIONAL INSTITUTES OF HEALTH, REPORT OF THE NIH PANEL TO DEFINE PRINCIPLES OF THERAPY OF HIV INFECTION 4 (1997).

reproduction, sexual intimacy, caring for one's self, interactions with others, and most fundamentally, life itself.

Individuals with HIV infection are necessarily limited in the major life activity of reproduction.[67] Any attempt to conceive a child puts the partner of an individual with HIV at risk of becoming infected. Successful conception carries the risk of a child born with HIV.[68] Those risks may not convince every individual with HIV to forgo reproduction entirely. But for every individual with HIV infection, the "conditions . . . under which" the decision about whether to engage in procreative activity, and the process of bearing a child for those who do, will be far different from that of the average person.[69]

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[67] Respondent correctly notes that reproduction is a major life activity. *See* Resp. Brief. The memorandum of law issued by the Department of Justice in 1988 which identified reproduction as a major life activity, *see* Memorandum from Douglas W. Kmiec, Acting Asst. Att'y Gen., Office of Legal Counsel, to Arthur B. Culvahouse, Jr., Counsel to the President (Sept. 27, 1988), *reprinted in* 8 Fair Empl. Prac. Manual (BNA) No. 641 at 405: 4-7, and Congress' numerous references to this memo, *see, e.g.*, *Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong., 1st Sess. (1980), *reprinted in* A&P Hearings S.933 at *118, are consistent with a common-sense understanding that reproduction is, indeed, a major life activity.

[68] Rhoda S. Sperling, et al., *Maternal Viral Load, Zidovudine Treatment, and the Risk of Transmission of Human Immunodeficiency Virus Type 1 from Mother to Infant*, 335 NEW ENG. J. MED. 1621 (1996) (noting rates of transmission from treated (7.6%) and untreated (22.6%) HIV infected mothers to infants).

[69] *See* 28 C.F.R. Pt. 36, App. at 610-11 (1996) (a person is substantially limited "when the individual's important life activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people.").

All individuals with HIV infection are also limited in the major life activity of intimate sexuality.[70] Some individuals may forgo sexual activity entirely, most will significantly alter the nature of their intimate acts, but for everyone, intimacy will carry conditions of potential risk to the sexual partner that are significantly different from those experienced by the average individual.[71]

At the most basic level, receiving the news that one is infected with a virus that systematically destroys one's immune defenses from the moment of infection, and will ultimately leave one vulnerable to an untimely death, dramatically affects the way one cares for oneself[72] and many other fundamental aspects of the way one lives one's life.

Virtually everything involved in caring for oneself day to day, from the profound to the trivial, is altered forever by an HIV diagnosis. A few nights of insomnia become cause for serious concern. A soda at lunch filled with ice cubes made from tap water becomes a deadly threat.[73] A person with

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[70] Like reproduction, intimate sexual activity is also a major life activity. *See* Memorandum from Douglas W. Kmiec, *supra* note 67. *See also* Resp. Brief.

[71] *See generally* DEPARTMENT OF HEALTH AND HUMAN SERVICES, HIV INFECTION AND AIDS: ARE YOU AT RISK?, *available at* www.cdcnac.org/book1.pdf.

[72] *See* 29 C.F.R. Pt. 1630, App. at 339 (listing caring for one's self as a major life activity).

[73] The CDC recommends that people with HIV infection not drink untreated tap water, because it frequently contains the potentially deadly bacteria cryptosporidium. CENTERS FOR DISEASE CONTROL AND PREVENTION, CRYPTOSPORIDIUM: A GUIDE FOR PERSONS WITH HIV/AIDS 2 (1998), *available at* www.cdc.gov/nchstp/hiv_aids/pubs/brochure/oi_cryp.html.

HIV must be attentive to diet or stress that might trigger immune suppression.[74] A person with HIV must be wary about changing careers for fear that a new health plan may leave him or her destitute in a few years. Life involves a series of decisions, including those that are large for everyone — what career to choose, what schooling to pursue, where to live, and whether to start a family — and those that, although small for the average person, have a greater impact for the person with HIV — what and when to eat, or which gynecologist or primary care physician to choose.[75] The prospect of a series of debilitating illnesses and an untimely death means that people with HIV will make every one of these decisions, and a host of others, under a different set of conditions from those experienced by the average person.[76]

As if transforming the most mundane aspects of daily living into potential threats to life itself were not enough, people who are HIV infected must adjust their lives to cope with the fear, stigma and prejudice of those around them.

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[74] *See* AMERICAN DIETETIC ASSOCIATION & CANADIAN DIETETIC ASSOCIATION, NUTRITION INTERVENTION IN THE CARE OF PERSONS WITH HUMAN IMMUNODEFICIENCY VIRUS INFECTION (1998), *available at* www.eatright.org/ahivinter.html.

[75] Obviously, a key determinant in making decisions is income level. But while poor and low-income HIV infected individuals will be faced with a different set of decisions than middle and upper-income HIV infected individuals, the decision-making of all such individuals will be significantly affected.

[76] Despite the advances made in drug treatments for HIV infection, "[e]veryone must understand that AIDS is not cured, not one person has seen his or her virus 'eradicated,' and the fight is bound to go on for years." *On the Road Between Euphoria and Failure*, PROJECT INFORM: PERSPECTIVE, November 1997, at 1, 3, *available at* www.projinfo.org/pub/23/euphoria.html. *See also* Brief of *Amicus Curiae* American Medical Association.

Despite all the scientific evidence to the contrary, many individuals still believe HIV is casually transmissible and that the very presence of those who have it is a threat.[77] Many believe those who have HIV are morally corrupt.[78] And many people simply do not want to be around people with HIV — not in the workplace, not in restaurants and bars, not anywhere.[79] An HIV diagnosis carries with it the certain knowledge that no one will look at you quite the same way again, that you may be in danger of losing your friends and your family, and that the attitudes of many will pose serious threats to your ability to survive with the disease — to keep your job and your insurance and to get essential medical care (whether or not related to HIV). That knowledge profoundly affects the way people with HIV interact with others,[80] making them circumspect about sharing what is now a central

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[77] A 1996 poll found that 17% of those polled feared they might become infected with HIV through casual contact, down from 29% in 1991. *Aids Fears Drop in U.S., Poll Shows*, REUTERS NEWSWIRE (Feb. 1, 1996). Another poll found that two-thirds of employees felt their co-workers would be uncomfortable around people infected with HIV, and 21% would favor firing or restricting such an employee. *National AIDS Fund Survey Finds HIV-Positive Employees May Face Continuing Workplace Discrimination*, PR NEWSWIRE (Oct. 28, 1997).

[78] A 1997 poll found that 31% of people thought that AIDS was a punishment for a decline in moral standards, and 40% believed it was the infected individual's own fault. Kim Painter, *People Less Judgmental, Fearful About AIDS*, USA TODAY, Oct. 9, 1997, at 10D (numbers of people condemning those with HIV down slightly since 1987).

[79] *See id.* (seven percent of people believe those with AIDS should be isolated from society); *National AIDS Fund Survey*, *supra* note 77.

[80] *See* EEOC Compliance Manual (CCH) § 902.3 (listing interacting with others as a major life activity); *Krocka v. Bransfield*, 969 F. Supp. 1073, 1083 (N.D. Ill. 1997) (recognizing interacting with others as major life activity).

part of their lives, hypersensitive to the collection and handling of medical information, and justly wary about how even casual remarks might shatter their lives.[81]

One need not know how asymptomatic HIV infection, symptomatic HIV infection, or AIDS itself has affected a particular individual's life to know that these impairments have substantially limited a major life activity. HIV infection will always do that, and thus, is "per se" a disability under the ADA.

IV. COURTS SHOULD NOT DEFER TO INDIVIDUAL HEALTH CARE PROVIDERS IN DETERMINING ISSUES OF "DIRECT THREAT."

Amici agree with Respondent that in determining whether a person with a disability poses a "direct threat" to health care providers, courts should not defer to the individual judgments of such providers. Such deference would subvert the balance that has been struck in disability anti-discrimination laws with regard to individuals with contagious diseases; under this balance, people with disabilities are protected from discrimination based on unfounded fears, and entities covered under the law are protected against actual threats to their health and safety.[82]

Amici wish only to emphasize to this Court the serious problem people with HIV infection, and people with disabilities generally, face in receiving quality health care in this country. While thousands of medical professionals serve people with disabilities every day with fairness, dignity, and

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[81] When stigma, fear and prejudice actually drive specific acts of discrimination, the ADA covers such discrimination under the "regarded as" prong of the definition of disability. *See* 42 U.S.C. § 12102(2)(C) (1994).

[82] *See Arline*, 480 U.S. at 287.

respect, those qualities are not present in all interactions with health care professionals.[83] Indeed, it is precisely because people with disabilities have experienced discriminatory treatment at the hands of the health care profession that the ADA's coverage of health care providers was of key importance to many *amici* and others during passage of the ADA.[84]

Amici also wish to emphasize the narrowness of the question before the Court. This case does not present the question of what deference should be given to medical providers who are making treatment decisions ostensibly in the "best interests" of their patients. Such questions are themselves complex because such decisions on the part of health care providers are often based on false assumptions about disability.[85] This case, by contrast, concerns solely what deference to afford health care providers who make decisions about risks that may accrue to *them* if they treat

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[83] *See* C. E. Lewis & K. Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected with the Human Immunodeficiency Virus*, 156 W. J. MED. 36 (1992) (48% of primary care physicians surveyed said they would not care for patients with HIV infection). *See also* Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 YALE J. ON REG. 1 (1996); Paul K. Longmore, *Medical Decision Making and People with Disabilities: A Clash of Cultures*, 23 J. L. MED. & ETHICS 82 (1995).

[84] *See* Feldblum, *supra* note 51, at 58 (noting final compromise in the Senate which resulted in broad coverage of public accommodations). *See also* S. REP. NO. 110-116, at 8 (quoting United States Commission on Civil Rights finding of discrimination in medical treatment); 136 CONG. REC. 17293 (statement of Rep. Waxman) (noting protection under ADA against discrimination by doctors).

[85] *See* Longmore, *supra* note 83, at 84-85. For this reason, *amici* urge the Court to avoid making any broad statements regarding deference to decisions by medical providers on treatment options.

patients with certain disabilities. In situations of this kind, deference to the judgment of the individual health provider is particularly unwarranted.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

Steven R. Shapiro
Jennifer Middleton
Matthew Coles
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street
New York, New York 10004
(212) 549-2600

Chai R. Feldblum
Counsel of Record
Associate Professor of Law
Federal Legislation Clinic
GEORGETOWN UNIVERSITY LAW CENTER
600 New Jersey Ave., N.W.
Washington, D.C. 20001
(202) 662-9595

Of Counsel:
Robert A. Long, Jr.
Alexandra T.V. Edsall
Grail P. Walsh
COVINGTON & BURLING
1201 Pennsylvania Ave., N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

February 1998 *Counsel for Amici Curiae*

APPENDIX

DESCRIPTIONS OF AMICI CURIAE

The AIDS Action Council ("AIDS Action") is the Washington, D.C. representative of over 2,400 community-based organizations and the one million HIV-infected individuals they serve. Since 1984, AIDS Action, the only national organization devoted entirely to federal advocacy on behalf of people living with HIV/AIDS, has worked for the development and implementation of federal initiatives to effectively address the needs of people living with HIV/AIDS. In this regard, AIDS Action was instrumental in the passage of the Americans with Disabilities Act ("ADA") in 1990.

The AIDS National Interfaith Network ("ANIN") is a non-sectarian, private non-profit organization founded in 1988. ANIN collaborates with a network of nearly 2,000 AIDS ministries across the United States. ANIN supports community-based AIDS ministries, educates AIDS service organizations, the religious community at large and the general public. ANIN's programs include networking/collaboration and referral activities as well as public education and federal AIDS policy advocacy.

The American Association on Mental Retardation ("AAMR") is the nation's oldest and largest interdisciplinary organization of professionals who work with people with mental retardation and other developmental disabilities in both institutional and community settings. AAMR develops human resources and leadership, promotes high quality services and supports that enable full community inclusion and participation, encourages research and its dissemination and application, advocates for progressive public policies, and influences public awareness and attitudes. The mission of the AAMR is to enhance the opportunities, human rights and choices of people with mental retardation and their families by

exchanging information that advances the skills and knowledge of individuals in the field.

The American Association of Retired Persons ("AARP") is a nonprofit membership organization of more than 30 million persons, age 50 and older. More than one-third of AARP's members are employed and many of them have disabilities. As the leading advocate for the rights of older workers, AARP is interested in insuring that the definition of disability is interpreted broadly to guarantee that the ADA fulfills the purposes that Congress intended.

The American Civil Liberties Union ("ACLU") is a nationwide, nonprofit, nonpartisan organization with nearly 300,000 members dedicated to preserving the principles of liberty and equality embodied in the Constitution. Since its founding in 1920, the ACLU has participated in numerous cases before this Court. Through its AIDS/HIV Project and its state affiliates, the ACLU Foundation engages in extensive advocacy and litigation to protect people with HIV, AIDS, and other disabilities from discrimination, working on more HIV-related litigation and legislation than any other legal organization. The ACLU AIDS Project was also a key participant in efforts to pass the ADA.

The American Council of the Blind ("ACB") is a national membership organization of people who are blind or visually impaired, with 69 affiliate organizations and 50,000 members nationwide. ACB strives to maximize the social, economic and cultural opportunities of all blind and visually impaired people by advocating for the improvement of educational and rehabilitation opportunities, services and facilities, building partnerships with public and private entities concerned with services for people who are blind, encouraging and assisting all blind persons to develop their abilities to the fullest extent possible, and promoting greater understanding of blindness and the capabilities of blind people.

The American Foundation for AIDS Research ("AmFAR") is the nation's leading nonprofit organization dedicated to the support of AIDS research (both basic-biomedical and clinical research), AIDS prevention, and the advocacy of sound AIDS-related public policy. Since 1985, AmFAR has invested more than $144 million in support for its programs, primarily through grants to more than 1,700 research teams.

The American Congress of Community Supports and Employment Services ("ACCSES") is a national not-for-profit organization representing more than 700 employment and community supports services providers nationwide. ACCSES is dedicated to improving employment opportunities, community services and residential options for the thousands of people with disabilities served by its members.

Since 1983, the AIDS Legal Referral Panel of the San Francisco Bay Area ("ALRP") has provided legal services to people with HIV or HIV-related legal problems in employment, healthcare, discrimination, shelter, and other areas. ALRP also protects and advances the civil rights — including workplace rights — of people with HIV through public policy advocacy.

The American Foundation for the Blind's ("AFB") mission is to enable persons who are blind or visually impaired to achieve equality of access and opportunity that will ensure freedom of choice in their lives. AFB accomplishes this mission by taking a national leadership role in the development and implementation of public policy and legislation, informational and educational programs, and quality services.

The American Network of Community Options and Resources ("ANCOR") is a national organization that represents and assists about 650 private agencies nationwide who together offer services and supports to more than 150,000 people with disabilities and their families. ANCOR provides

leadership in the development and provision of innovative, high quality supports in the community.

Americans for Democratic Action, Inc. ("ADA," for purposes of this paragraph only) is an independent liberal political organization, founded in 1947, dedicated to promoting individual liberty and economic justice. ADA publishes a weekly legislative newsletter for liberal activists, a quarterly newsletter, special reports, including an annual voting record report that ranks Members of Congress according to a liberal quotient, based on a full spectrum of domestic and international policy issues. In addition to its legislative advocacy, ADA maintains a political action committee to support liberal candidates for Congress. ADA also engages in independent campaign activity in support of Presidential candidates.

Americans With Disabilities Vote is a nonpartisan, nonprofit organization whose mission is to encourage citizens with disabilities to register, vote and participate in the political process.

The Arc of the United States, a national organization on mental retardation, is an open membership organization made up of people with mental retardation and their families, friends, interested citizens, and professionals in the disability field. With 140,000 members in 1,100 state and local chapters nationwide, The Arc is the largest voluntary organization devoted solely to working on behalf of the estimated seven million people with mental retardation in the United States and their families. The Arc has been intensely involved in pursuing federal legislation which supports the rights of people with mental retardation, including enactment of the ADA.

Bay Area Lawyers for Individual Freedom ("BALIF") is a minority bar association comprised of over 500 gay, lesbian and bisexual members of the San Francisco Bay Area legal community. BALIF promotes the professional interests of its

members and the legal interests of the gay, lesbian and bisexual community at large, by participating in public policy debates concerning the rights of lesbians, gay men and bisexuals, including persons living with HIV. BALIF co-founded the San Francisco-based AIDS Legal Referral Panel to provide free legal assistance to persons living with HIV, now serving more than 3,000 clients annually.

The Bazelon Center for Mental Health Law is a national legal advocacy organization representing people with mental disabilities. The Bazelon Center seeks the full integration into the community of people with mental disabilities by protecting their rights to choice and dignity and expanding their access to housing, employment and other services, including medical and dental care.

The Blinded Veterans Association, a nonprofit and tax-exempt organization, was founded in 1945 by a group of veterans blinded during World War II. The Association was incorporated in 1947, and in 1958 was chartered by the United States Congress to represent all blinded veterans.

The Center for Law in the Public Interest is a 26-year-old, non-profit law firm specializing in impact litigation, policy-oriented research, counseling and legislative advocacy, primarily in the areas of civil rights, consumer protection and environmental/land use law. Since the passage of the ADA, the Center has litigated many cases under the Act, and has established an anti-discrimination project devoted toward providing effective representation to persons with HIV.

The Center for Women Policy Studies ("CWPS"), founded in 1972, is a national nonprofit, multiethnic and multicultural, feminist policy research and advocacy institution. The National Resource Center on Women and AIDS policy, founded in 1987 by CWPS, is a leader in conducting original research and addressing critical AIDS policy issues from women's diverse perspectives. CWPS has produced more than

20 research, advocacy and policy reports, including discussions of the disabling health conditions faced by women who do not fall under the surveillance and Social Security Administration definitions of AIDS.

Children and Adults with Attention Deficit Disorders ("CH.A.D.D.") is a non-profit, parent-based organization formed in 1987 to better the lives of individuals with ADD and those that care for them. Through family support and advocacy, public and professional education and encouragement of scientific research, CH.A.D.D. works to ensure that individuals with ADD reach their inherent potential. Based in Plantation, Florida, CH.A.D.D. has over 30,000 members and 520 chapters nationwide.

The Cities Advocating Emergency AIDS Relief Coalition ("CAEAR Coalition") is a national grassroots nonprofit organization that advocates for increased funding for the Ryan White CARE Act with a special focus on Titles I and III. The CAEAR Coalition is a membership organization involving people living with HIV/AIDS, community-based organizations, and Planning Councils and grantees under Title I and Title III of the Ryan White CARE Act.

The Coalition For The Homeless was founded in 1980 on the principle that decent shelter, sufficient food, and affordable housing are fundamental rights in a civilized society. The Coalition educates, advocates for and provides direct services to homeless persons. The Coalition's Scattered Site Housing Programs provides decent apartments, personal support, and vital services to homeless people living with AIDS.

The Committee For Children is a national child advocacy organization that works for the safety, health, welfare and protection of all children, both in the United States and where possible abroad.

The Disability Rights Council of Greater Washington ("DRC"), established in 1992 as a regional advocacy organization, is organized to address systemic discrimination against people with disabilities in every aspect of society. The DRC's goal is to promote, secure and protect the full participation of people with disabilities in the community, which the DRC believes will strengthen society as a whole.

The Employment Law Center ("ELC") is a project of the Legal Aid Society of San Francisco, a private, non-profit organization. The primary goal of the Center is to improve the working lives of disadvantaged people. Since 1970, ELC has represented clients in cases covering a broad range of employment-related issues including discrimination on the basis of race, gender, age, disability, pregnancy, citizenship, sexual orientation and national origin. In addition, ELC has been involved with issues such as occupational health and safety, language rights and the characterization of employees as independent contractors. ELC has represented clients faced with discrimination on the basis of their disability, including those with HIV/AIDS. ELC monitors state and federal rulings of importance to disabled persons. In addition, it files amicus briefs in cases raising issues concerning the interpretation and enforcement of the ADA.

The Evangelical Lutheran Church in America ("ELCA") is the largest Lutheran denomination in North America and the fifth largest Protestant church body in the United States. The ELCA has approximately 11,000 member congregations, which in turn have approximately 5.2 million individual members nationwide. Through the Lutheran Office of Governmental Affairs in Washington, D.C., the ELCA engages in advocacy on public policy issues before the Congress of the United States of America.

The Gay and Lesbian Medical Association ("GLMA") is an organization of nearly 2,000 lesbian, gay, bisexual, and

transgendered physicians, medical students, and their supporters in all 50 states and 12 countries. Founded in 1981, GLMA works to combat homophobia within the medical profession and in society at large, and to promote quality health care for lesbian, gay, bisexual, and transgendered patients.

The Gay Men's Health Crisis is the world's oldest and largest not-for-profit AIDS organization, providing services to people with AIDS and their loved ones, educating the public, and advocating for fair and effective AIDS policies.

The Human Rights Campaign ("HRC") is the nation's largest gay and lesbian civil rights organization. HRC is devoted to fighting and ending discrimination against gay men and lesbians, and to protecting the basic civil and human rights of those Americans. HRC is also specifically devoted to fighting discrimination against people living with HIV and AIDS. To these ends, HRC has provided federal advocacy and media and grassroots support on a range of legislative initiatives affecting gay men, lesbians, and people living with HIV/AIDS, including the ADA and the Employment Nondiscrimination Act.

The International Conference on Transgender Law and Employment Policy ("ICTLEP") was founded in 1992 to undertake educational activities relating to laws affecting transgenders, to develop changes to provide relief from discriminatory legislation affecting transgenders, and to educate the general public and the legal profession about special problems unique to transgenders. ICTLEP is also concerned with how law affects those transgenders who contract AIDS and is interested in how AIDS law affects all people who similarly suffer from the disease and from the discrimination which accompanies it.

Lawyers for Human Rights – The Lesbian and Gay Bar Association of Los Angeles ("LHR"), an affiliate of the Los

Angeles County Bar Association organized in 1979, is a mutual support network for lesbian, gay, and bisexual lawyers, law students and legal workers in the Los Angeles area. LHR's mission includes the provision of a strong leadership presence of and for lesbian, gay and bisexual persons in the legal profession and in the community at large, through education, legal advocacy, and participation in political and civil activities.

The Learning Disabilities Association of America ("LDA") is a national, nonprofit, volunteer organization including individuals with learning disabilities, their families, and professionals. LDA is dedicated to enhancing the quality of life for all individuals with learning disabilities and their families, to alleviating the restricting effects of learning disabilities, and to supporting endeavors to determine the causes of learning disabilities. LDA seeks to accomplish this through advocacy, education, research and service and through collaborative efforts

The Legal Action Center is a nonprofit law and policy organization specializing in AIDS, alcohol, and drug issues. The Center's attorneys, who helped draft the ADA protections at stake in this case, represent individuals with HIV disease and the programs that serve them to resolve discriminatory practices in employment, housing, health care, zoning and other areas of life.

The National Association of People with AIDS ("NAPWA"), founded in 1983, advocates on behalf of all people living with HIV and AIDS in order to end the pandemic and the human suffering caused by HIV/AIDS.

The National Association of Protection and Advocacy Systems ("NAPAS"), which was founded in 1981, is a membership organization for the nationwide system of protection and advocacy ("P&A") agencies. P&As are mandated under the Developmental Disabilities Assistance and

Bill of Rights Act, 42 U.S.C. 6000 *et seq.*, the Protection and Advocacy for Mentally Ill Individuals Act, 42 U.S.C. 10801 *et seq.*, and the Protection and Advocacy for Individual Rights Program, 29 U.S.C. 794e, to provide legal representation and related advocacy services on behalf of all persons with disabilities. In fiscal year 1996, P&As served over 1,000,000 people with disabilities through a variety of mechanisms: individual case representation, systemic advocacy, information and referral and education efforts. NAPAS facilitates the coordination of P&A activities, provides P&As with training and technical assistance and represents their interests before the Executive and Legislative Branches of Government.

The National Association of Social Workers, Inc. ("NASW"), a nonprofit professional association with over 155,000 members and chapters in each state and internationally, is the largest association of social workers in the world. The Maine Chapter of NASW is an affiliated chapter located in the state in which this action arose. NASW is devoted to promoting the quality and effectiveness of social work practice, to advancing the knowledge base of the social work profession, and to improving the quality of life for all people. NASW has issued a policy statement on HIV/AIDS and is committed to ensuring that people with HIV/AIDS receive the benefit and protection of federal laws protecting persons with perceived or actual disability.

The National Center for Lesbian Rights ("NCLR"), founded in 1977, is a national legal and advocacy organization dedicated to achieving full civil and human rights for all lesbians and their families. NCLR provides litigation, legal resources, advocacy and community education services to lesbians and their families. Also, by appearing in prominent national media, NCLR is dedicated to bringing lesbian civil rights to the forefront of the American consciousness in an accessible and compelling manner.

The National Council of the Churches of Christ ("NCC") in the USA is the nation's oldest and largest ecumenical body. Its members are 34 Protestant, Anglican and Orthodox communions with an aggregate membership in excess of 50 million. The NCC does not purport to speak for all of its members but rather for its general assembly which includes representatives of each member communion.

The National Council of Jewish Women, Inc. ("NCJW") is a volunteer organization, inspired by Jewish values, that works through a program of research, education, advocacy an community service to improve the quality of life for women, children and families, and strives to ensure individual rights and freedoms for all. Founded in 1893, NCJW has 90,000 members in over 500 communities nationwide. NCJW has a historical commitment to civil rights issues and was actively involved in passage of the ADA.

The National Employment Lawyers Association ("NELA") is a voluntary membership organization of over 3,000 lawyers who regularly represent employees in labor, employment, and civil rights disputes. NELA is one of the largest organizations in the United States whose members litigate and counsel individuals, employees, and applicants on claims arising out of the workplace. One of the primary purposes of NELA is to represent, protect, and defend the interests of employees involved in workplace disputes, including workers who are involved in litigation under the ADA.

The National Gay and Lesbian Task Force ("NGLTF") works to eliminate prejudice, violence and injustice against gay, lesbian, bisexual and transgendered people at the local, state and national levels. As part of a broader social justice movement for freedom, justice and equality, NGLTF is creating a world that respects and celebrates the diversity of human expression and identity and where all people may fully participate in society.

The National Health Law Program is a public interest law firm that works with legal advocates and others to improve access to health care by low-income people through policy analysis, advocacy and litigation.

The National Hemophilia Foundation ("NHF") seeks to enhance the quality of life and promote the health of people with hemophilia, von willebrand disease, and other bleeding disorders. With 43 chapters nationwide, NHF supports clinical research and provides education to professionals, the bleeding disorders community, and the general public. NHF also delivers patient and community services, advocates on behalf of the bleeding disorders community, and makes health policy recommendations. NHF addresses treatment issues, HIV, and related health problems and offers a range of information services and publications through its information center (HANDI).

The National Latino/a Lesbian and Gay Organization ("LLEGO") was established in 1987 to strengthen Latina Lesbian, Latino Gay, bisexual and transgender communities at local, national and international levels by facilitating access to cultural, political, and community development resources. LLEGO is a constituency based organization with over one hundred affiliates nationwide in 47 cities, 18 states and Puerto Rico.

The National Lesbian and Gay Health Association ("NLGHA") is a nonprofit 501(c)(3) organization of individual health care professionals, clinics and programs that provide primary health care focusing on the needs of lesbians and gay men. The mission of NLGHA is to enhance the quality of health and health care for lesbians and gay men through education, policy development, advocacy, and the facilitation of health care delivery.

The National Lesbian and Gay Law Association ("NLGLA") was founded in 1988 as a national association of

lawyers, judges, other legal professionals, law students and affiliated lesbian and gay legal organizations. NLGLA's mission is to promote justice in and though the legal profession for the lesbian and gay community in all its diversity, including, but not limited to, bisexuals, transgenders, people of color, and people with disabilities, including HIV.

The National Minority AIDS Council ("NMAC") is a national advocacy and technical assistance organization serving a membership of over 600 community-based organizations providing HIV/AIDS services to people of color throughout the United States and its territories.

The National Multiple Sclerosis Society's mission is to end the devastating effects of Multiple Sclerosis. The Society focuses on providing services to people with MS through its chapters and by funding research projects on MS.

The National Native American AIDS Prevention Center's (NNAAPC) mission is to prevent the spread of HIV and related diseases in American Indian, Alaska Native, and Native Hawaiian communities, and to improve the quality of life of those in our communities infected and affected by HIV. NNAAPC provides technical assistance, training, case management services, research and policy advocacy to and for Native Americans throughout the United States.

The National Organization on Disability ("NOD") promotes the full and equal participation of America's 49 million men, women and children with disabilities in all aspects of life. NOD was founded in 1982 as an outgrowth of the United Nations International Year of Disabled Persons. NOD is the only national network organization concerned with all disabilities, all age groups and all disability issues.

The National Organization for Rare Disorders ("NORD") is the unique federation of more than 140 voluntary health organizations dedicated to helping people with rare "orphan

diseases" and assisting the organizations that serve them. NORD is committed to the identification, treatment and cure of rare disorders through programs of education, advocacy, research and patient services.

The National Parent Network on Disabilities ("NPND") provides a presence and a voice in Washington, DC for parents of children, youth and adults with disabilities. NPND serves as a networking force to assist its 170 member organizations to work together on all disability related issues that affect their constituents. The major goal of NPND is to help parents and families to have all of the information, education, assistance and support needed to do the very best they can on behalf of their family member with a disability.

The National Therapeutic Recreation Society ("NTRS") represents and assists professionals and organizations involved in the provision of therapeutic recreation services to assist people with disabilities achieve maximum independence and rehabilitation. NTRS offers technical assistance, information and referral services to agencies, institutions and individuals on professional issues, trends, and directions in the field of therapeutic recreation.

The New York Lawyers for the Public Interest, Inc. ("NYLPI") is a nonprofit law office that works to protect the rights of people with disabilities. Through its Disability Law Center, NYLPI seeks to protect and promote the civil rights and liberties of people with disabilities and to enable them fully to participate in the mainstream of American life. NYLPI has been extremely active on issues involving the application of the ADA to discrimination in employment, government services, and public accommodation. NYLPI represents numerous individuals and files amicus curiae briefs on its own behalf and on behalf of disability and civil rights groups in cases around the country addressing the application of the ADA.

NISH (formerly National Industries for the Severely Handicapped) maximizes employment opportunities for people with severe disabilities through providing professional and technical assistance to not-for-profit community rehabilitation programs to encourage and assist their participation in the Javits-Wagner-O'Day (JWOD) Program and other employment or training activities as appropriate. NISH is the central nonprofit agency designated by the Committee for Purchase from People who are Blind or Severely Disabled to provide assistance to Work Centers interested in obtaining federal contracts under the JWOD Program. It is one of NISH's goals to expand employment, personal advancement and placement of people with disabilities by maximizing opportunities created by the JWOD Program while taking advantage of other employment opportunities. The civil rights of people with severe disabilities is of utmost priority to NISH primarily for the protection of employment rights. However, NISH also supports the protection of civil rights for people with disabilities in all areas to promote independent living and greatest opportunities for an integrated life with the rest of society.

Project Inform is the Nation's leading AIDS information and advocacy agency representing thousands of people with AIDS.

RESOLVE was founded in 1974 as a national, nonprofit consumer organization. RESOLVE's mission is to provide timely, compassionate support and information to individuals who are experiencing infertility and to increase awareness of infertility issues through advocacy and public education. For more than twenty years, RESOLVE has provided help to thousands of people experiencing the infertility crisis.

Title II Community AIDS National Network includes Ryan White Title II grantees and the people living with AIDS they serve.

The Union of American Hebrew Congregations ("UAHC") is the synagogue arm of the Reform movement and represents 1.5 million Reform Jews in more than 870 congregations nationwide. For over a century, the UAHC has fought passionately for religious liberty and tolerance for all Americans, believing these to be among the greatest gifts America has bestowed upon its citizens and the world. The UAHC played an active role in securing the passage of the ADA.

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

BRIEF OF THE CITY OF LOS ANGELES AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

JAMES K. HAHN
City Attorney
City of Los Angeles
Counsel of Record

TIMOTHY B. MCOSKER
Chief Deputy City Attorney
CHARLES I. GOLDENBERG
Senior Assistant City Attorney
DAVID I. SCHULMAN
Deputy City Attorney
200 No. Main Street, Rm. 1800
Los Angeles, CA 90012
(213) 485-5408

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
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STATEMENT OF INTEREST

Amicus curiae the City of Los Angeles submits this brief pursuant to Rule 37.5.

This case concerns whether a dentist may discriminate against a person with asymptomatic HIV disease despite the provisions of the Americans with Disabilities Act, 42 U.S.C. Sections 12101 *et seq.*

We write to share our AIDS legal expertise in support of the respondent as the jurisdiction which enacted the nation's first AIDS discrimination law, and which has long advised staff who face risks like those faced by the appellant dentist.

SUMMARY OF ARGUMENT

To create a system that permits professionals to refuse even remote risks when they serve the public is deeply divisive to society.

ARGUMENT

We agree with the Court of Appeals for the First Circuit that (1) respondent suffers a disability that impairs a major life function within the meaning of the Americans with Disabilities Act ("ADA"), 42 U.S.C. Sections 12101 *et seq.* and that (2) appellant failed to raise an adequate direct threat defense. *Abbott v. Bragdon,* 107 F. 3d 934 (1st Cir. 1997). The bases for this decision have been well discussed and developed in other briefs. We write to urge the Court to consider these arguments in

light of our experience as the jurisdiction which enacted the nation's first AIDS discrimination law, and which employs many who face threats in the workplace like those respondent presented appellant.

We advise staff who face such risk in far-less controlled circumstances than appellant's dental office. Our paramedics must pull bloody traffic accident victims out of jagged metal sheets, our police confront bloody, hostile knife-wielding suspects, and our firefighters rescue bleeding persons from smoky buildings littered with broken glass. They render care to all residents, without regard to HIV status, because they understand the fundamental shift in bloodborne infection control brought about by hepatitis B and HIV – that all blood, at all times, from all sources, must be treated *as if* it is infectious.

We enacted our AIDS discrimination law, the nation's first, Los Angeles Municipal Code Sections 45.80 *et seq.*, in 1985, shortly after movie star Rock Hudson's disclosure of his AIDS diagnosis created world-wide interest and concern about the epidemic for the first time.[1] We did so because it was unclear whether state or federal disability rights laws would be held to protect persons with HIV and AIDS, yet we had received persuasive testimony from city residents about wide-ranging acts of discrimination against them.

Upon commencing enforcement of our new law, we repeatedly found that AIDS discrimination was rooted in

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[1] Shortly thereafter, the cities of West Hollywood, San Francisco, Berkeley and Oakland enacted similar laws.

deep-seated fears of infectiousness.[2] For the public at large, these fears were based on its ignorance about what was meant by the statement that "HIV was 'contagious' ". We found that the public imported its own experiences with such infectious illnesses as colds or the flu, and society's past experience with such more-easily transmitted epidemics as cholera or the plague and, quite naturally, applied them to AIDS.

For our staff who encounter blood in the workplace, their concerns involved their unfamiliarity with the *degree* of risk posed by bloodborne disease. We found they needed training and assistance to learn to separate their irrational fears from professional assessment of the real, but remote, risk in their workplace, a risk reduced far further upon proper and consistent use of protective gear and protocols.

For complex reasons including the reticence of the media to be frank, the public did not understand at that time, the mid-to-late 1980s, what public health officials by then most clearly understood: that HIV's *vector of transmission* was fundamentally different.[3] To our surprise, we

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[2] For a general description of our enforcement experiences, see David I. Schulman, "AIDS Discrimination: Its Nature, Meaning and Function," 12 *Nova Law Review* 1113 (1988), an expanded version of our testimony to the Presidential Commission on the Human Immunodeficiency Virus Epidemic on March 16, 1988, during hearings held at Vanderbilt University in Nashville, Tennessee.

[3] In fact, the Centers for Disease Control (now the Centers for Disease Control and Prevention) had speculated a mere *fifteen months* after it published history's first AIDS case reports in June 1981 that AIDS might be transmitted by a bloodborne

found that we often resolved our investigations without litigation because our inquiries required respondents to learn how HIV actually *was* transmitted.[4]

We believe the insight that flowed from our experiences may be useful to the Court: that AIDS discrimination laws, whether specific to AIDS like our ordinance, or which incorporate HIV into their definition of disability like the Americans with Disabilities Act, are not just civil rights laws. The only case to approach this understanding is *Citizens for Uniform Laws v. County of Contra Costa*, 233 Cal. App. 3d 1468, 1475, 285 Cal. Rptr. 456 (1991), which held that state civil rights law did not preempt the county's AIDS discrimination law because it promoted the public health goal of combatting the AIDS epidemic by promoting HIV testing through protection of the rights of those who test positive. We are aware, and

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agent, 31 *Morbidity and Mortality Weekly Report* ("*MMWR*") 577 (Nov. 5, 1982). This speculation was strengthened considerably just two months later when it reported an infant had developed AIDS following a blood transfusion from a person later found to have it. 31 *MMWR* 652 (Dec. 10, 1982).

[4] A result so remarkable it became the basis for a presentation at the 3rd International Conference on AIDS, and an early AIDS law review article. See David I. Schulman, Mitchell Karp, and Norman Nickens, "Municipal AIDS Discrimination Laws as Public Health Education Tools for Preventing HIV Transmission" (abstract accepted for presentation at the 3rd International Conference on Acquired Immunodeficiency Syndrome, held June 1-5, 1987, in Washington, D.C.). See also Robert Roden, "Educating Through the Law: The Los Angeles AIDS Discrimination Ordinance," 33 *UCLA Law Review* 1410 (1986).

support, briefs submitted to the Court that argue similarly that AIDS discrimination laws perform public health functions.

But we wish to imply more. The encounter between the AIDS epidemic and law has called a new understanding into play, one we believe is important for the Court to take into account in deciding this case, in understanding that respondent's claim is not merely a disability rights claim to dental care. It is suggested further by another dimension to our enforcement experience.

We found that AIDS discrimination in some ways is like other forms of discrimination, in that it is the unfair treatment of individuals based upon irrational fears and prejudices about certain groups. But it is different even from that family of discrimination law – disability rights law – into which federal and state law has placed it. AIDS discrimination alone emanates out of an epidemic, and we believe it is this that must centrally affect the Court's deliberations in this case. Indeed, we believe it requires an AIDS jurisprudence.

This jurisprudence would recognize that epidemics threaten the ties that bind communities together. Some are driven to victimize others in order to bind the rest back together. AIDS discrimination laws combat this by establishing standards of reasonable behavior for members of a community, even when they are frightened, indeed, especially when they are frightened.

An AIDS jurisprudence would recognize that AIDS discrimination laws educate the public about the essential fact about HIV – how it is transmitted – and that education saves lives. But it would also recognize that AIDS

discrimination laws, by establishing fair standards of behavior, combat the ancient impulse to fracture during epidemics, and thereby maintains the health of the body politic.

From the beginning, we found that AIDS discrimination laws resist the fracture and blame so endemic to epidemics. They do so by establishing standards that express a practical, able-to-be-lived vision of how to behave when we are frightened. Our research suggests this is an unprecedented role for law.[5] Law characteristically *reinforced* societies' impulse to scapegoat, to blame.[6] And characteristically as well, they blamed people with already "spoiled identities".[7]

An eruption of a new jurisprudence, a new legal frame, though rare, is a traditional part of the legal process.[8] AIDS discrimination laws' way of establishing an ethical standard of behavior for frightened people would seem to be such an event. It recalls the exchange between the plague doctor Rieux and the journalist Rambert in Camus's *The Plague*.

Rieux disputes the journalist's contention that his dedication and effort were heroic:

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[5] See, for example, William H. McNeil, *Plagues and People* (1976).

[6] *Ibid.*

[7] See Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (1963), for comment about why those singled out are invariably those already possessed of "spoiled identities".

[8] See Robert Cover, "The Supreme Court 1982 Term: *Nomos* and Narrative," 97 *Harvard Law Review* 4 (1983).

> However, there's one thing I must tell you: there's no question of heroism in all this. It's a matter of common decency. That's an idea which may make some people smile, but the only means of fighting a plague is – common decency.[9]

Another character, Tarrou, explains this eruption of awareness further.

> All I maintain is that on this earth there are pestilences and there are victims, and it's up to us, so far as possible, not to join forces with the pestilences. That may sound simple to the point of childishness; I can't judge if it's simple, but I know it's true. You see, I'd heard such quantities of arguments, which very nearly turned my head, and turned other people's heads enough to make them approve of murder; and I'd come to realize that all our troubles spring from our failure to use plain, clean-cut language. So I resolved always to speak – and to act – quite clearly, as this was the only way of setting myself on the right track.[10]

It is this understanding that would be overlooked should the Court reject respondent's claim for dental care as a disqualified ADA claim. It arises amidst an epidemic, one that has provoked the best and worst in people, as Camus advised. We will not parse the line of cases that has denied ADA-based AIDS discrimination claims, despite the statute's and legislative history's "plain, clean-cut language", for that will be done in other briefs.

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[9] Albert Camus, *The Plague* (1972) (Stuart Gilbert trans., Vintage Books ed.) at 154.

[10] *Id.* at 236.

We argue, instead, that appellant's claim that he may refuse to care for the respondent despite overwhelming public health standards to the contrary, emotionally compelling as his claim is for himself and his loved ones, is no way to fight an epidemic. And though the authors of this brief themselves do not face the remote risk that would be faced by appellant, we are responsible for the safety of staff who do.

We understand how disturbing this prospect is for judges and others who think about the risk faced by loved ones who may be police, firefighters – or dentists. But we have learned through our work with staff, our regular lectures to trainees and to medical and dental students, and our work with the dental profession itself,[11] that adjustment to the remote but real risk of HIV in the workplace is just that, an adjustment. It is no excuse to victimize, to scapegoat . . . or to refuse care.

---

[11] See David I. Schulman, "The Dentist, HIV and the Law: Duty to Treat, Need to Understand," *CDA [California Dental Association] Journal*, Sept. 1993, at 45.

CONCLUSION

For all the reasons set forth above, the judgment of the Court of Appeals for the First Circuit should be affirmed.

Dated: February 5, 1998

Respectfully submitted,

JAMES K. HAHN
City Attorney
City of Los Angeles
TIMOTHY B. MCOSKER
Chief Deputy City Attorney
CHARLES I. GOLDENBERG
Senior Assistant City Attorney
DAVID I. SCHULMAN
Deputy City Attorney

By JAMES K. HAHN
Counsel of Record

Attorneys for Amicus Curiae

Supreme Court, U.S.
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No. 97-156

IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,
Petitioner,
v.
SIDNEY ABBOTT, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

MICHAEL L. ILE
LEONARD A. NELSON
KARLA L. KINDERMAN
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
(312) 464-4600

CARTER G. PHILLIPS
MARK E. HADDAD *
SIDLEY & AUSTIN
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 736-8000

JACK R. BIERIG
JOSEPH S. MILLER
SIDLEY & AUSTIN
1 First National Plaza
Chicago, IL 60603
(312) 853-7000

Counsel for Amicus Curiae
American Medical Association

February 6, 1998

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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QUESTIONS PRESENTED

Amicus curiae will address the following questions:

Does an individual with early, or "asymptomatic," HIV disease have a "disability" within the meaning of the Americans with Disabilities Act?

Under the Americans with Disabilities Act, should a court defer to a health care practitioner's subjective judgment about the presence of a "direct threat" of infection posed by an individual who seeks treatment in the office of that practitioner, when the overwhelming weight of scientific evidence demonstrates that any such risk is insignificant?

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICUS CURIAE*

This case calls upon the Court to revisit the framework, established in *School Bd.* v. *Arline*, 480 U.S. 273 (1987), for evaluating claims of discrimination by persons who suffer from an infectious disease.[1] Specifically, this case presents two important questions: First, does a person with early HIV disease, sometimes called "asymptomatic HIV disease," have a "disability" as that term is defined

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

in the Americans with Disabilities Act ("the Act" or "the ADA")? Second, to what extent should courts defer to a health care practitioner's subjective judgment about the presence of a "direct threat" of infection in a particular practice setting? As the nation's largest organization of physicians, *amicus* American Medical Association ("AMA") has a vital interest in both questions.

The AMA's nearly 300,000 member physicians are regularly called upon to care for persons with infectious diseases, including early HIV disease. The AMA and its members thus have a substantial interest in ensuring that these patients receive treatment that reflects informed and medically reasonable judgments about the risks of infection. To that end, for more than a decade, the AMA has sponsored extensive efforts to ascertain the facts about HIV disease and its transmission and to disseminate those facts to physicians and the public.

Most notably, in an ethical opinion adopted in 1992, the AMA confirmed, specifically in the context of HIV disease, a physician's age-old ethical obligation to treat patients with a communicable disease. AMA, *Code of Medical Ethics* § 9.131 (1996-97 ed.), AMA *Amicus* App. 1a. This opinion, embraced after extensive debate and analysis, holds that "[a] physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV," and that "[p]ersons who are seropositive should not be subjected to discrimination based on fear or prejudice." *Id.* This duty to treat is further reinforced by an additional ethical opinion that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute invidious discrimination" (*id.* § 9.12, AMA *Amicus* App. 1a)—an opinion that the AMA, in educational materials addressing the physician's legal obligations under the ADA, has made clear forbids refusal to treat patients with HIV. These ethical opinions have been widely disseminated by the AMA, have been cited in numerous judicial opinions and journal articles, and are the subject of extensive and continuing AMA efforts and initiatives aimed at public awareness and continuing physician education.

The AMA believes that the medical considerations underlying its position regarding the ethical obligation of physicians to treat individuals who are HIV+ are highly relevant to the proper resolution of this case. The plain medical fact is that HIV disease, even in its early stages, has profound effects on a person's health. HIV-infected individuals require access to routine medical services. Moreover, the general consensus of medical opinion, both in 1994 and today, is that there is no significant risk of transmission of HIV from patient to practitioner arising out of the delivery of routine care in the medical or dental office by a practitioner who takes certain straightforward "universal precautions." In these circumstances, it is not medically appropriate to refuse to provide such care in an office setting to individuals with early HIV disease.

MEDICAL BACKGROUND

We begin with a discussion of infectious diseases generally and, in particular, important aspects of HIV disease. This discussion includes both the progression of HIV disease from infection through its severe stages and the risks of HIV transmission from patients to health care workers and specifically to dentists. In analyzing the nature, duration, severity, and risks of HIV transmission, we focus on data from the 1994 time frame, *i.e.*, the time when respondent Abbott was denied treatment, because, as the court of appeals correctly concluded, "neither the service provider nor the prospective recipient of the service may prove or disprove the direct threat defense by relying on medical evidence not available when treatment was refused." Pet. App. 18a.

A. Infectious Diseases in the United States

Each year, millions of Americans contract infectious, or communicable, diseases.[2] See Centers for Disease Control & Prevention ("CDC"), 46 Morbidity and Mortality Weekly Report ("MMWR") 1259 (Jan. 1998) (table 1) (year-end figures for select diseases). More than 200 different infectious diseases have been identified, including hepatitis, lyme disease, meningitis, pneumonia, tetanus, tuberculosis, and HIV disease. See *Control of Communicable Diseases in Man* ix-xv (A. Benenson ed., 15th ed. 1990). The consequences of contracting an infectious disease vary widely, ranging from minor irritation to paralysis or death. In some cases, a person with an infectious disease may have no outwardly apparent symptoms at all.

B. Human Immunodeficiency Virus and HIV Disease

The condition known as acquired immunodeficiency syndrome ("AIDS") was first reported to the CDC in 1981. See CDC, *Pneumocystis Pneumonia—Los Angeles*, 30 MMWR 250 (1981). In 1983, HIV, the pathogen responsible for AIDS, was identified. As more information about the nature and continuous progression of the HIV disease process accumulated, the term AIDS "became outdated from a clinical perspective." Michael S. Saag, *Clinical Spectrum of Human Immunodeficiency Virus Diseases*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 203, 203 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997) (hereinafter "Saag"). In current usage, "AIDS" is primarily an epidemiological category

[2] The words "infectious" and "communicable" are often used interchangeably. An "infectious disease" or "communicable disease" refers to a disease that is capable of being transmitted to others at some time. When someone is currently capable of transmitting a disease to others, he or she is referred to as being "infectious" or "contagious," or (less frequently) "communicable." *Dorland's Illustrated Medical Dictionary* 359, 372, 838 (28th ed. 1994).

that is used to track the number of new cases of persons with advanced HIV disease, rather than a clinical term that is relevant to patient care. *Id.*

HIV is a human virus that can infect and replicate in numerous types of human cells. Paul A. Volberding, *Clinical Spectrum of HIV Disease*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 123, 124 (Vincent T. DeVita, Jr. *et al.* eds., 3d ed. 1992) (hereinafter "Volberding"). Certain immune-system T-cells—those with a molecule known as CD4—are particularly susceptible to HIV infection. *Id.* Infected T-cells (T-cells that are "CD4+") eventually die, and as the number of such cells decreases, the body's ability to fight infection also decreases. The infected individual's CD4+ cell count is thus "the best predictor of the [individual's] relative risk for developing HIV-related opportunistic diseases" at any given time. Saag at 203. As a result, HIV disease is viewed as progressing in stages that correspond to a range of CD4+ cell levels in the patient. *Id.* at 203-04; Volberding at 126.

1. *Progression and Effects of HIV Disease*

HIV disease begins with infection by HIV. There are three basic routes of HIV transmission: (1) invasive exposure to blood, blood products, or other infectious bodily fluids, as in individuals who share contaminated needles for intravenous drugs or who receive contaminated blood; (2) prenatal or perinatal exposure (*i.e.*, from mother to infant)[3]; and (3) intimate sexual contact with a partner who is HIV+. Volberding at 127; Anthony S. Fauci & H. Clifford Lane, *The Acquired Immunodeficiency Syndrome (AIDS)*, in *Harrison's Principles of Internal Medicine* 1392, 1393 (Eugene Braunwald *et al.* eds., 11th ed. 1987).

[3] HIV may also be transmitted postnatally from mother to infant through breast milk. Committee on Pediatric AIDS, *Human Milk, Breastfeeding, and Transmission of Human Immunodeficiency Virus In the United States*, 96 Pediatrics 977, 977 (1995).

"HIV infection induces a disease process that is continuous and progressive." Volberding at 125. There is, in fact,

> a single, continuous disease process beginning with the initial exposure to the infectious agent and terminating in the advanced forms of immune deficiency, with death resulting from the complex interactions between the HIV infection itself and the secondary opportunistic infections and malignancies.

Id. at 126. With advances in treatment, increasing numbers of patients with HIV are surviving longer, but the disease is generally fatal. See Saag at 208 ("it appears inevitable that all patients with HIV-1 infection will ultimately succumb to their disease"). Apart from a number of HIV-related gynecological manifestations, "there is little gender difference in opportunistic processes and HIV disease progression." Rebecca Clark, *Clinical Manifestations and the Natural History of Human Immunodeficiency Virus Infection in Women*, in *Medical Management of AIDS in Women* 115, 115 (Deborah Cotton & D. Heather Watts eds., 1997); see also Howard L. Minkoff & Jack A. DeHovitz, *Care of Women Infected With the Human Immunodeficiency Virus*, 266 JAMA 2253, 2255-56 (Oct. 23/30, 1991) ("There is no specific evidence that nongynecologic opportunistic manifestations of HIV disease differ between men and women.").

The median time from estimated initial HIV infection to the development of symptoms of advanced HIV disease is roughly 10 to 12 years. Saag at 209; Volberding at 129. Importantly, the rate at which HIV disease progresses varies widely from person to person. The reasons for this variability are not well understood. According to Saag, "the rate of disease progression is quite variable, with some individuals progressing to AIDS within months of the initial infection and others remaining free of AIDS-defining conditions for more than 15 to 20 years (i.e., long-term nonprogressors)." Saag at 209; see also Volberding at 129 (same). Accordingly, "[f]or any HIV-1-

infected individual," however, "the likelihood of the disease progression is difficult to predict." Saag at 203.

The first stage of HIV disease is known as "acute retroviral syndrome" or "acute seroconversion syndrome." Volberding at 127-28; Saag at 204-05. This complex of symptoms generally begins two to six weeks after initial infection. Saag at 204. The symptoms, which include fevers, lymphadenopathy (*i.e.*, chronic abnormal enlargement of the lymph nodes), pharyngitis, and diffuse skin rash, most closely resemble acute mononucleosis or a severe case of the flu. Volberding at 127. Most symptoms resolve within 14 to 21 days, Saag at 205, but lymphadenopathy often persists throughout early HIV disease, Volberding at 127. These symptoms are indicative of HIV's direct and immediate attack on the cells of the immune system. After the HIV cell attaches to the CD4 receptor on a lymph cell, its membrane fuses with that of the lymph cell and its viral genetic material is injected into the host. Volberding at 124. The host can then become a factory for the production of more copies of HIV's genetic material, and these copies spread to other cells. *Id.* Indeed, within two to four weeks after initial infection, high levels of circulating HIV are detectable. Within one to three weeks after the onset of acute retroviral syndrome, HIV antibodies are detectable. Saag at 205.

The second stage of HIV disease is known as early, or asymptomatic, HIV disease. It is characterized by a CD4+ count of 500 to 750 cells/mm^3. *Id.* at 205; Volberding at 126 (Table 9-1). This is the longest stage of HIV disease, with a typical duration of 10+ years. Volberding at 126 (Table 9-1, line 3). Lymphadenopathy is the only typical symptom that is readily apparent to the patient, and it usually persists from the time of acute seroconversion. Saag at 205-06; Volberding at 128. A consistent pattern of irregularities in the blood and immune symptoms can also be detected with laboratory tests. Volberding at 128. Finally, a range of dermatological abnormalities and oral lesions are not uncommon during

this phase. Saag at 206. This stage of the disease requires consistent monitoring and routine medical care to prevent, so far as is practicable, the onset of opportunistic infections. Volberding at 130-31.

As was noted above, CD4+ cell count is the most important marker of the disease's progression, and it declines steadily throughout early HIV disease. As HIV continues its attack on the immune system, a person with HIV experiences "an insidious, progressive decline in CD4+ cells (40 to 80 cells/mm^3 per year)." *Id.* at 207. Without antiretroviral therapy, there is "an enormously high degree of viral production throughout all stages of infection," depriving the immune system of any respite from HIV's assault. *Id.* at 206.

As the CD4+ count drops below 500 cells/mm^3, the individual is likely to pass from the asymptomatic to the symptomatic stage of HIV disease. *Id.* at 207; Volberding at 126 (Table 9-1). Symptomatic HIV disease can range in duration, from a brief period ending in death to a number of years. Volberding at 126 (Table 9-1). Symptoms at this stage include night sweats, chronic diarrhea, fever, weight loss, fatigue, and more frequent or severe skin and oral lesions. Saag at 207; Volberding at 131-32. Indeed, "[n]early every organ system in the body can be affected," and "the effect of symptoms on the patient ranges from minimal to devastating." Volberding at 131. When an individual with HIV reaches the final stages of the disease, CD4+ counts fall below 200 cells/mm^3 and continue to decline. Opportunistic infections such as *pneumocystis carinii* pneumonia, encephalitis, and B-cell lymphoma begin to appear. Saag at 207; Volberding at 133. When CD4+ counts drop below 50 cells/mm^3, an increasing array of opportunistic infections must be treated. Saag at 208. Brain disorders and involuntary weight loss, or "wasting," are also common at this stage. *Id.*

With aggressive antiretroviral therapy and prophylactic treatments designed to fend off opportunistic infections,

this stage of the disease can be managed for some time despite the profound immunosuppression brought about by HIV. Saag at 207-09; Volberding at 133-34. Nevertheless, deaths at this late stage of HIV disease remain common. Saag at 208. As one authority has put it,

> the diagnosis of terminal-stage HIV-1 disease is usually based on an inability to control the symptoms of disease, because no treatments are available for the particular disorder or, more commonly, because available treatments become ineffective.

Id. at 208-09.

The effects of HIV disease are not limited to the clinical effects already discussed. Individuals who have learned that they are HIV+ must adapt to a daunting new personal circumstance:

> HIV leads to a deterioration of the patient's health, requires ongoing medical and subspeciality care, results in frequent hospitalizations, can be painful, often requires embarrassing and invasive procedures, and usually leads to premature death. It also disrupts the patient's ability to engage in usual activities such as school or work and has a devastating psychologic and emotional effect on the individual and his or her family.

Sandra Y. Lewis *et al., Pediatric and Family HIV: Psychosocial Concerns Across the Continuum of Disease*, 31 Nursing Clinics N. Am. 221, 221 (Mar. 1996). It is not difficult to recognize that, in light of this harsh reality, "HIV is the most feared disease in our society." Jimmie C. Holland *et al., Psychiatric and Psychosocial Aspects of HIV Infection*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 347, 347 (Vincent T. DeVita, Jr. *et al.* eds., 3d ed. 1992) (hereinafter "Holland *et al.*"). And the realization that HIV has transformed—and almost certainly severely shortened—one's life, "can be accompanied by profound feelings of shock, disbelief, depression, loneliness, hopelessness, personal grief, guilt, anger, and fear." Margaret A. Chesney & Susan Folkman, *Psycho-*

logical Impact of HIV Disease and Implications for Intervention, 17 Psychiatric Clinics N. Am. 163, 163 (Mar. 1994).

Indeed, individuals with early HIV disease typically must confront a number of psychosocial issues that affect their quality of life. These include:

> (1) disclosing their serostatus to significant others; (2) seeking meaning in living with an HIV diagnosis; (3) making critical decisions about safer sexual behavior and drug use, reproductive choices, and custody planning for children; (4) adopting healthy coping strategies; (5) seeking social support; (6) managing social distancing in relationships; and (7) coping with the uncertainty of the disease course.

Lynda S. Doll & Beth A. Dillon, *Counseling Persons Seropositive for Human Immunodeficiency Virus Infection and Their Families*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 533, 534 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997). These challenges not only touch every major area of life activity, but they significantly limit the individual's ability to proceed with daily life without regard to the HIV disease. See *id.* at 534-38 (detailed review of each issue). See also AMA, *HIV Blood Test Counseling: Physician Guidelines* 3-5 (2d ed. 1993).

Finally, the unpredictable rate at which HIV progresses heightens the psychological impact and anguish of being diagnosed with the disease. "[U]ncertainty becomes the central issue of daily life as each body sensation is analyzed for evidence of progression or new infection." Holland *et al.* at 348. The fact that HIV disease may suddenly and rapidly progress to an advanced and debilitating stage severely complicates planning and making decisions about work and family life.

2. *HIV Transmission in the Health Care Setting*

The principal means of HIV transmission in the health care setting is exposure to the blood, blood products, or

other infectious bodily fluids of a person with HIV. The primary risk of transmission from a patient to a health care practitioner comes from percutaneous exposure, such as a needlestick or a cut with a sharp object.[4] See generally David M. Bell, *Human Immunodeficiency Virus Transmission in Health Care Settings: Risk and Risk Reduction*, 91 Am. J. Med. 3B-294S (1991 Supp. 3B).

a. Transmission.—Since the first reported case of occupationally transmitted HIV infection in the health care setting occurred in 1983, the public health community has collected and analyzed epidemiological data to estimate the risk of HIV infection from patients to health care practitioners, including dentists. See David K. Henderson *et al.*, *Risk for Occupational Transmission of Human Immunodeficiency Virus Type 1 (HIV-1) Associated With Clinical Exposures*, 113 Annals Internal Med. 740, 740 (Nov. 15, 1990). Data have been collected in different ways. All of which indicates that the risk of HIV transmission from a patient to a dentist is not significant, as long as easily followed universal precautions are used.

First, public health authorities have created a "passive surveillance" system for collecting and tracking reports of HIV transmission from patient to health care worker. In 1991, the CDC began tracking the number of health care workers who report occupationally acquired HIV infection. Ruthanne Marcus & David M. Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 645, 645 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997) (hereinafter "Marcus & Bell"). As of December 1994, the CDC's surveillance data specific to health care workers showed 42 documented cases and 91 possible cases of HIV infection involving

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[4] In some circumstances (not including routine dental procedures for a patient with HIV disease), infections may be transmitted by cutaneous exposure (such as a splash on the skin), or mucocutaneous exposure (such as exposure to the mucous membranes of the sinus).

patient care.[6] *Id.* at 646. None of the documented cases involved a dental practitioner. *Id.* As of June 1997, the number of documented cases of HIV transmission from patient to health care practitioner had risen to 52, but, as before, none of the health care practitioners was a dentist. CDC, *HIV/AIDS Prevention: Facts About Surveillance of Health Care Workers With HIV/AIDS* (Aug. 1997). Given the number of dental procedures performed across the country each year, the lack of a single documented case of HIV transmission from patient to dentist strongly indicates that the risk of such transmission is not significant.[6]

Researchers also have conducted a number of long-term prospective cohort studies that assess the likelihood that a health care worker will become HIV+ after a documented percutaneous exposure to HIV-infected blood. "These studies," published in 1994 or earlier, "have consistently indicated that the risk of acquiring HIV infection after a percutaneous exposure to HIV-infected blood is approximately 0.3%," *i.e.*, 3 in 1,000. Marcus & Bell at 648. This figure of 3 in 1,000 is not, as some have implied, a measure of the risk that a dentist who treats a patient

[5] A "documented case" involves a health care worker's documented conversion from HIV seronegative to HIV seropositive status in connection with a known percutaneous, mucous membrane, or skin exposure. Marcus & Bell at 646. A "possible case" involves a health care worker who reported an occupational exposure to HIV and who had no identifiable behavioral or transfusion risks, but for whom there is no documented proof that, prior to the occupational exposure, the worker did not have HIV. *Id.*

[6] The CDC also has other data linking HIV disease and employment. As of December 31, 1994, the CDC had received reports of 304,651 adults with AIDS for whom employment information was available. Of these people, 14,591 (or 4.8%) had been employed in health care settings. In the workforce as a whole, by comparison, approximately 5.7% of workers are employed in health services. In other words, according to 1994 data, health care workers were "not overrepresented among reported cases of AIDS." Marcus & Bell at 645.

with HIV will become infected with HIV. Rather, that figure must be multiplied by the likelihood that the dentist will be exposed to HIV-infected blood or other fluid through a percutaneous injury in the first place. For dentists, such injuries occur infrequently—on average, once every four months.[7] Moreover, as Marcus & Bell indicate, this 0.3% risk estimate of practitioner HIV infection after exposure to infected blood includes many different types of injuries from source patients at various stages of HIV disease. *Id.* Factors unique to dentistry might tend to lower this estimate. For example, because the needles used to administer local anesthetic are of a smaller bore than those used for many medical procedures, *e.g.*, to draw blood, sticks from such needles will expose dentists to smaller amounts of infected blood. Stephen E. Gruninger *et al.*, *Human Immunodeficiency Virus Type 1 Infection Among Dentists*, 123 J. Am. Dental Ass'n 57, 62-63 (Mar. 1992). It is therefore "difficult . . . to rationalize how accidental needlesticks could be a significant HIV transmission route in the dental operatory." *Id.* at 62.

b. Universal Precautions.—The CDC promulgated recommendations based on universal precautions in 1987. Elizabeth A. Bolyard & David M. Bell, *Universal Precautions in the Health Care Setting*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 655, 656 (Vincent DeVita, Jr. *et al.* eds., 4th ed. 1997). The principle of universal precautions assumes that blood, certain bodily fluids, and tissues of *all* patients must be considered infectious and treated accordingly. *Id.* at 656. The CDC

[7] The baseline rate of needlestick injuries among dentists has steadily declined during the era of universal precautions. Data from 1993 indicate that, at that time, dentists suffered a percutaneous injury roughly once every four months. Jennifer L. Cleveland *et al.*, *Occupational Blood Exposures in Dentistry: A Decade in Review*, 18 Infect. Control & Hosp. Epidemiol. 717, 720 (Oct. 1997) ("the rate of percutaneous exposures among U.S. dentists decreased steadily from approximately one injury per month in 1986 to one injury every 4 months in 1993"). Given the decline from 1986 to 1993, however, the baseline rate may well be even lower today.

has promulgated and continually updated guidelines based on universal precautions, both for general health care settings and for specialized areas of practice, including dentistry.[8] *Id.* at 656-57. The core practices of universal precautions ("UP") can be readily summarized:

> UP emphasizes the use of appropriate barrier precautions (e.g., gloves, gowns, and facial protection) routinely to prevent mucocutaneous blood contact. The precautions also emphasize the need for prevention of percutaneous injuries through care in the use of needles and other sharp instruments and during disposal of these devices, including the use of conveniently placed sharps disposal units. Proper handwashing, linen and waste handling, and disinfection and sterilization of instruments and other reusable equipment are recommended.

Id. at 657. These practices focus on limiting the health care worker's exposure to blood-borne pathogens such as HIV.

The application of universal precautions to the field of dentistry is straightforward. For example, according to the CDC, "medical gloves (latex or vinyl) always must be worn by [dental health care workers] when there is a potential for contacting blood, blood-contaminated saliva, or mucous membranes." CDC, *Recommended Infection-Control Practices for Dentistry, 1993* 42 MMWR RR-8, at 3 (May 28, 1993), Pet. App. 185a. Likewise, "[c]hin-length plastic face shields or surgical masks and protective eyewear should be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry." *Id.*, Pet. App. 186a; see also Jennifer L. Cleveland & Donald W. Marianos, *Special Considerations for Dentistry*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997)

[8] *See, e.g.*, CDC, *Recommended Infection-Control Practices for Dentistry, 1993*, 42 MMWR RR-8 (May 28, 1993), Pet. App. 181a-199a.

(discussing infection control practices for dentistry). As the CDC states, "[w]hen implemented, these recommendations should reduce the risk of disease transmission in the dental environment." *Recommended Infection-Control* at 1 (summary), Pet. App. 181a. Significantly, the CDC guidelines do not suggest that the risks of HIV transmission are reduced by performing routine medical or dental procedures in hospital, rather than office, settings.

Petitioner notes that these public health guidelines contain no "definitive statement of the significance of the risk to dentists." (Pet. 21.) This criticism is misplaced. The universal precautions guidelines are not intended to provide an exhaustive report of epidemiological data or a static risk estimate. The data regarding the quantum of risk, already reviewed in detail above, are readily available in peer-reviewed journals accessible to petitioner and all other interested health care workers.

Given petitioner's focus on the possibility of HIV infection from aerosolized pathogens (Pet. 16, 19-20), it is useful to focus on epidemiological evidence on this subject. Marcus & Bell recently summarized the evidence regarding aerosol transmission as follows:

> Although inhalation of particles of aerosolized blood may pose a theoretical risk of blood borne pathogen transmission, *no case of such transmission has been documented*. Transmission of blood borne pathogens by aerosols would require generation of aerosolized particles of blood, the presence of infective blood borne pathogens in these aerosolized particles, and the deposition of a sufficient number of infective blood particles in the respiratory tract or on the mucous membranes of a susceptible host to cause infection. . . . Aerosolized HIV has been detected in laboratory studies, although these studies should not be interpreted to mean that HIV is aerosolized in a clinical setting or that HIV is transmitted by this route. . . . Until further research is conducted, the possibility of occupational transmission of HIV

through aerosolized blood should be considered theoretical.

Marcus & Bell at 651 (emphasis added); see also David M. Bell, *Human Immunodeficiency Virus, supra,* at 3B-298S ("There are no known instances of transmission of a blood-borne pathogen by aerosol in a clinical setting."). Any "theoretical" risk of transmission should not alter the conclusion that, on the basis of all known data, there is no significant risk of HIV transmission from patient to dentist during routine dental care provided in accordance with universal precautions.

The American Dental Association's policy statements reflect the absence of significant risk to dentists in providing routine dental care in an office setting using universal precautions. According to the relevant policy statement, first promulgated in 1988 and renewed in 1991, "there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed." American Dental Ass'n, *Policy on AIDS, HIV Infection and the Practice of Dentistry* (1991), J.A. 225. Further, according to the ADA, "[p]atients with HIV infection may be *safely treated in private dental offices* when appropriate infection control procedures are employed." *Id.* (emphasis added).

3. *Ethical Obligation to Treat Infected Patients*

Finally, the duty to treat patients with communicable diseases, and more broadly, the recognition that the practice of medicine requires physicians to accept the risk of transmission of those diseases, is a cornerstone of medical ethics. See, *e.g.*, Ezekiel Emanuel, *Do Physicians Have An Ethical Obligation To Treat Patients With AIDS?*, 318 N. Eng. J. Med. 1686 (1988). In ethical opinions adopted and disseminated well before the facts of this case arose, the AMA has confirmed that physicians may not ethically refuse to treat a patient solely because that patient is seropositive for HIV. AMA, *Code of Medical Ethics*, § 9.131 (1996-97 ed.), AMA *Amicus* App. 1a-2a; see *id.* § 9.12, AMA *Amicus* App. 1a.

SUMMARY OF ARGUMENT

The ADA reflects a national commitment to ensure that no individual is treated unfairly because of a disability and, in particular, to ensure that no person is denied access to health care services because of a medically unreasonable judgment based upon an actual, historical, or perceived disability. The ADA was enacted against the backdrop of this Court's seminal holding, in *School Bd.* v. *Arline*, 480 U.S. 273 (1987), that persons with contagious diseases may be considered handicapped within the meaning of section 504 of the Rehabilitation Act of 1974. The ADA's broad definition of disability confirms Congress's agreement with this Court that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment," and that "contagiousness" is particularly likely to give rise to the "public fear and misapprehension" that often leads to discrimination. 480 U.S. at 284 (footnote omitted). It is therefore critical under the ADA, as it was under the Rehabilitation Act, to ensure that decisions about access to health care for individuals who are disabled within the meaning of the Act are based upon "reasonable medical judgments." *Id.* at 288; see, *e.g.*, 42 U.S.C. 12101(a)(3) (Act needed to remedy discrimination against the disabled in "health services").

I.

The Act defines "disability" in three ways. Two of these are relevant here. First, the Act defines a "disability" as an impairment that substantially limits a major life activity. The term also includes being "regarded as" having such an impairment.

Respondent Abbott is covered by both statutory definitions. First, even where outward symptoms have not manifested, a diagnosis of infection with HIV typically affects every aspect of a person's life and substantially limits mul-

tiple life activities. Second, petitioner Bragdon denied respondent access to the routine dental care that he offered to others solely on the basis of respondent's HIV infection. He thus regarded her HIV infection as a physical impairment that substantially limited her eligibility to obtain health care—a crucial aspect of "caring for one's self" that has long been recognized as a major life activity. Thus, the court of appeals correctly concluded that respondent has a "disability" within the meaning of the ADA.

II.

The Act permits a place of public accommodation to deny services to an individual where "such individual poses a direct threat to the health or safety of others." In *Arline*, this Court concluded that, in the context of the possible transmission of an infectious disease such as tuberculosis or HIV, assessing the presence of a "significant health and safety risk[]", 480 U.S. at 287, entails an inquiry "based on reasonable medical judgments given the state of medical knowledge." *Id.* at 288 (quoting AMA *Arline Amicus* Br. at 19). Accordingly, although courts ordinarily should accord substantial deference to a reasonable medical or dental judgment regarding the presence of a health or safety risk, such deference is appropriate only when it is "reasonable" and consistent with "the state of medical knowledge." *Id.*

Here, there was a firm consensus among both private and public health care professionals about the absence of a significant risk of transmission in the treatment context at issue. In these circumstances, petitioner Bragdon's contrary judgment cannot be regarded as reasonable. See *General Elec. Co.* v. *Joiner*, 118 S. Ct. 512 (1997). Moreover, the deference ordinarily shown to a professional judgment is unwarranted where, as here, the practitioner whose judgment contravenes the consensus view was directly involved in the case, did not obtain an independent, medically reasonable opinion before refusing to treat respondent in his office, and did not adhere to an important ethical tenet of his profession.

ARGUMENT

I. GIVEN THE STATE OF MEDICAL KNOWLEDGE AND PRACTICE IN 1994, RESPONDENT HAD A "DISABILITY" AS DEFINED BY THE ACT

The Act defines a "disability" in two ways that are relevant here. First, a "disability" is "a physical or mental impairment that substantially limits one or more of the major life activities of [the] individual." 42 U.S.C. § 12102(2)(A). Second, a "disability" includes "being regarded as having such an impairment," *i.e.*, a physical or mental impairment that substantially limits one or more of a person's major life activities. 42 U.S.C. § 12102(2)(C). Given the facts about HIV as they were known in 1994, virtually all persons suffering from early HIV disease, including respondent Abbott, should be found to have a disability under the first definition. In addition, petitioner's refusal to treat respondent solely on the basis of her early HIV disease demonstrates that he regarded her as having a substantially limiting impairment, bringing this case within the alternative definition of "disability."

A. Persons With Early HIV Disease Have An Impairment That Likely Substantially Limits Many Major Life Activities

The court of appeals' conclusion that HIV, "whether symptomatic or asymptomatic, comprises a physical impairment under the ADA" (Pet. App. 6a) is fully consistent with the current state of medical knowledge about HIV disease. See pages 5-9, *supra*. Petitioner has not challenged that conclusion in this Court. Indeed, to suggest otherwise would conflict with established medical facts about the nature and progression of HIV disease.[9]

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[9] *See also* 28 C.F.R. § 36.104 (1997) (DOJ regulations implementing the Act's public accommodations provisions, defining "physical

Petitioner challenges, instead, the lower courts' conclusion that reproduction—"intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations," (Pet. App. 7a)—is a "major life activity" for purposes of the definition of "disability."[10] To focus exclusively on reproduction as *the* major life activity substantially limited by HIV, however, is to ignore much of the profound impact of HIV disease. Even asymptomatic HIV disease has a debilitating effect on many other major life activities. These include life-shaping decisions such as what education to pursue, what family and financial obligations to assume, what employment opportunities to seek or to forgo and, at bottom, how to spend the limited time left to live. It is simply inconsistent with human experience to say that HIV disease, which profoundly affects a person's ability to plan for and engage in a host of basic life activities, does not substantially limit them.[11]

Recognizing that HIV infection can have a substantial effect on major life activities of virtually all those who are

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impairment" as, *inter alia*, "HIV disease (whether symptomatic or asymptomatic)"); 45 C.F.R. § 84.3(j)(2) (1997) (HHS regulations implementing the Rehabilitation Act, defining "physical impairment" as, *inter alia*, a physiological disorder of the hemic and lymphatic systems). HIV disease attacks and impairs the body's immune system relentlessly from the moment of infection.

[10] *Amicus* concurs with the court of appeals' conclusion that reproduction encompasses a cluster of life activities of profound scope and widely recognized importance, and is comparable to the life activities identified by regulation as "major." *See* 28 C.F.R. § 36.104 (1997) ("The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."); 45 C.F.R. § 84.3(j)(2)(ii) (1997) (same).

[11] The impact of HIV infection on these basic life decisions is made all the more profound and intractable by the unpredictable nature of the clinical course of an individual person's HIV disease. The variability in life expectancy for someone infected with HIV is such that no individual can know whether he or she will live for 10 or 15 years or more—or die within months or a few years. *See* page 6-7, *supra*.

infected is fully consistent with the nature and purpose of the Act. The Act is intended to prevent discrimination against disabled individuals in arenas as diverse as employment, 42 U.S.C. § 12112(a), entitlement to government services, *id.* § 12132, and access to public accommodations such as health care services, *id.* 12182(a). See *id.* § 12101(a)(3) ("discrimination against individuals with disabilities persists in such critical areas as . . . health services"). In order to achieve this far-reaching goal, Congress patterned the Act's definition of "disability" on the Rehabilitation Act's broad definition of "handicap," expressly invoking Rehabilitation Act statutory and regulatory standards for interpreting the ADA. See 42 U.S.C. § 12201 (requiring adherence to Rehabilitation Act standards). The Rehabilitation Act's definition of "handicap" had itself been expanded in 1974, one year after its original enactment. See *Arline*, 480 U.S. at 278. Congress had concluded that its forerunner, restricted to limitations on employability,

> was too narrow to deal with the range of discriminatory practices in housing, education, and health care programs which stemmed from stereotypical attitudes and ignorance about the handicapped.

Id. at 287 n.3.

This history confirms that the "major life activities" criterion that Congress chose to define "disability," while necessary to provide some limits on the broad scope of an Act that otherwise would cover all "impairments," was never intended to become a linguistic obstacle course that would defeat the Act's fundamental remedial purpose for individuals with serious, irreversible, life-threatening medical conditions. To the contrary, Congress intended to give "disability," like the predecessor term "handicap," a broad definition so that the civil rights protection that it intended to afford all disabled Americans in fact would be available to them. See 42 U.S.C. § 12101(b)(2) (Act's purposes include "provid[ing] clear, strong, consistent, enforceable standards addressing discrimination").

The *Arline* decision, on which the Act is significantly based, further reinforces the appropriateness of construing the statutory term "disability" to encompass a disease with the characteristics of early HIV disease. *Arline* suggests that meritless claims are to be winnowed out less by narrowly construing the definition of who is handicapped than by a careful analysis of whether an individual is otherwise qualified for relief. See 480 U.S. at 285 ("the definition of 'handicapped individual' is broad, but only those individuals who are both handicapped *and* otherwise qualified are eligible for relief") (emphasis in original). Indeed, this Court's holding in *Arline*—that "[a]llowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of" the Rehabilitation Act (*id.* at 284)—is perforce true with respect to the basic purpose of the more far-reaching Americans with Disabilities Act.

For this reason, the Act should be construed to "ensure that [disabled] individuals are not denied jobs or other benefits," such as equal access to basic medical care, "because of the prejudiced attitudes or the ignorance of others" with respect to their disabilities. *Id.* HIV disease is both contagious and generally fatal—a combination of attributes with a unique potency for prompting irrational and discriminatory responses. To construe the Act to deny protection to those with this disease because of a perceived inadequate impact on major life activities would unjustly narrow the scope of this landmark legislation.

B. Persons With Early HIV Disease Are Likely To Be Regarded As Having An Impairment That Substantially Limits Many Major Life Activities

The Act also includes a definition of "disability" that protects persons who are not currently suffering from an impairment that substantially limits a major life activity. In particular, the third subsection of 42 U.S.C. § 12102(2) defines having a "disability" as "being regarded as having such an impairment," whether or not such impairment

presently exists. 42 U.S.C. § 12102(2)(C). In 1994, as the lower courts correctly discerned, respondent Abbott did have an impairment that substantially limited her major life activities. Furthermore, petitioner himself regarded her as having such an impairment, thus bringing her within the scope of the Act's protection by virtue of Section 12102(2)(C).

The basis for petitioner's refusal to provide respondent routine dental care in his office was unquestionably her HIV disease. Petitioner regarded respondent as having an impairment because she was HIV+. The question, therefore, is whether his refusal to provide dental care in his office substantially limited a major life activity.

For two independent reasons, obtaining needed health care is a crucial element of one of the "major life activities" covered by the Act. First, both HHS's Rehabilitation Act regulations and the Justice Department's public accommodations regulations expressly place "caring for one's self" at the top of the list of illustrative "major life activities." See note 10, *supra* (quoting regulations). Obtaining health care services, including routine dental care, is surely a primary component of caring for one's self. Indeed, obtaining such care is especially important for persons suffering from a progressive immunosuppressive disorder such as HIV disease, for whom infection from untreated conditions can pose serious additional risks. See pages 7-8, *supra*.

Second, Congress expressly included the "professional office of a health care provider" among the Act's list of public accommodations that are forbidden to discriminate on the basis of disability. 42 U.S.C. § 12181(7)(F). By treating the provision of health care services as a public accommodation, Congress made plain its view of the critical importance of obtaining access to health care. See also 42 U.S.C. § 12101(a)(3) (finding that "health services" are a "critical" area in which discrimination on the basis of disability persists). For this reason as well, obtaining health care may properly be covered as a major life ac-

tivity. *Cf. Arline*, 480 U.S. at 283 n.10 ("working" is a major life activity because the Act forbids employment discrimination).

Accordingly, petitioner's refusal to treat respondent on the basis of her HIV disease means that respondent has a "disability" under the Act's "regarded as" prong and thus triggers review of the medical reasonableness of that refusal. As this Court observed in *Arline*, by amending the definition of "handicap" to include the "regarded as" component, "Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness." 480 U.S. at 284 (footnote omitted); see *id.* at 284-85 & nn.4-13. These important truths, recognized by this Court more than a decade ago, should guide the Court's interpretation of the ADA, which is designed to remedy discrimination on the basis of disability.

II. ALTHOUGH COURTS ORDINARILY SHOULD DEFER TO THE REASONABLE MEDICAL JUDGMENTS OF PRIVATE HEALTH CARE PROFESSIONALS, PETITIONER'S JUDGMENT WAS NOT MEDICALLY REASONABLE AND THEREFORE IS NOT ENTITLED TO DEFERENCE

Even though respondent was unquestionably disabled within the meaning of the ADA, the question remains whether filling her cavity would have posed "a direct threat" to petitioner's "health or safety." See 42 U.S.C. § 12182(b)(3). The Act defines "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." *Id.* The Act thus requires an inquiry not into whether *all* risk may be eliminated, but whether all *significant* risk may be eliminated.

Decisions about the presence of a "direct threat" of infection must be based, not on prejudice or stereotypes, but on reasonable medical judgments.[12] Under the Act, therefore, a health care professional need do no more—and no less—than make a medically reasonable decision about whether and how to treat a contagious patient in light of available epidemiological data and guidelines regarding the significance of and means of reducing the risk of transmission. On this issue, petitioner asserts that the court of appeals erred in not deferring to his assessment of the significance of the risk. See Petitioner's Merits Br. 42-44.

In *Arline*, this Court held that, when assessing the significance of risks related to infectious disease, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288. There is no reason, under the ADA, to deviate from this presumption for cases involving matters—such as infectious disease—that are particularly the province of public health officials. The CDC's guidelines, for example, typically reflect a consensus view of both public and private medical authorities, and therefore should be accorded deference in applying the ADA. This case, however, poses the question left open in *Arline* regarding the extent to which deference also may be due to the judgments of private health care practitioners. See *Arline*, 480 U.S. at 288 n.18.

Ordinarily, substantial deference should be given to employment or accommodation decisions that are genuinely

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[12] *See* 28 C.F.R. § 36.208(c) (1997) ("In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on *reasonable judgment that relies on current medical knowledge or on the best available objective evidence*, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.") (emphasis added). *Cf. Arline*, 480 U.S. at 288 (listing the same factors for assessing risk).

and rationally founded upon a reasonable, private, medical judgment. See, *e.g.*, AMA *Arline Amicus* Br. at 21-22 n.16; *Kampmeier* v. *Nyquist*, 553 F.2d 296, 299 (2d Cir. 1977) (upholding school board decision to exclude students with vision in only one eye from contact sports because officials "relied on [a reasonable] medical opinion that [the] children . . . [were] not qualified."). Indeed, in disability cases not involving matters of public health, there typically will be no definitive public health guidance available, and so the opinions of private physicians or dentists will inevitably be at issue. These professionals are generally well-qualified to make judgments regarding potential threats to health or safety posed in various scenarios.

More specifically, in cases involving infectious diseases, the parties should not be precluded from relying on private medical opinions when those opinions are medically reasonable and satisfy established standards for expert testimony. This conclusion is fully consistent with the core principle established in *Arline*, that assessments of the significance of risk should be "based on reasonable medical judgments given the state of medical knowledge" concerning the "nature," "duration," "severity," and "probability" of transmission of the disease. *Arline*, 480 U.S. at 288 (quoting AMA *Arline Amicus* Br. at 19). Thus, for example, where a party can show that there is no single consensus but rather a range of reasonable views within the medical profession concerning a disputed issue,[18] then, at the very least, that party should be permitted to present to a factfinder the evidence supporting the party's position. Indeed, where, for example, a physician, alleged to have violated the Act, demonstrates that he or she obtained or made a reasonable medical judg-

[18] This could be the case, for example, when a particular disease is too new for a public health consensus to have formed, when new treatments have been developed but only preliminarily tested, or when substantial research calls materially into question the bases for existing guidelines.

ment, that fact normally should be dispositive that there has been no violation of the Act.

In this case, however, the judgment of petitioner Bragdon was not reasonable and should be given no deference. First, that judgment was inconsistent with the consensus among public and private health authorities in 1994 that providing routine dental care to patients infected with HIV in a dentist's office posed no significant risk of harm to the dentist if universal precautions were followed. The CDC guidelines in place in 1994 on this point were fully consistent with, and explicitly supported and amplified by, the guidance provided and widely disseminated by both the American Dental Association, and more generally, by the AMA. See, *e.g.*, J.A. 225; AMA *Amicus* App. at 1a-2a. Where a consensus exists that there is "little risk" to providing a particular treatment to a patient with a particular type of infection (J.A. 225), private deviations from that view should be deemed presumptively unreasonable.

Second, petitioner did not rely on any substantial scientific evidence in support of his position. As this Court recently reemphasized in the context of admissibility determinations, *all* expert testimony must be scrutinized with an eye toward determining whether the opinions propounded actually draw any support from the underlying scientific proof:

> Trained experts commonly extrapolate from existing data. But nothing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence which is connected to existing data only by the *ipse dixit* of the expert. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.

General Elec. Co. v. *Joiner*, 118 S. Ct. 512, 519 (1997). The court of appeals' detailed analysis of the evidence petitioner offered to defend his refusal to treat respondent identified numerous "analytical gap[s]" between underlying data and the view sought to be supported. Only

after the court found all this evidence wanting, considered separately and cumulatively, (Pet. App. 22a-29a), did it finally conclude, consistent with the principles in *Joiner*, that petitioner "failed to present meaningfully probative evidence that treating Ms. Abbott would have posed a medically significant threat to his health or safety." *Id.* at 30a.

Third, deference is less appropriate where, as here, a party seeks to invoke it in defense of his own unilateral action. Notably, petitioner did not attempt, contemporaneously with the event at issue, to seek out an independent private medical opinion concerning the degree of risk posed by treating respondent. This failure is significant, for the question as left open in *Arline* contemplated a scenario in which an employer had sought out an independent private medical opinion. See *Arline*, 480 U.S. at 288 n.18 ("This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians *on which an employer has relied.*") (emphasis added). Here, in contrast, petitioner's actions were based on his own judgment in an area—treatment of HIV-infected patients—where he had no special claim to expertise and thus where an unfounded fear might distort his judgment.

Finally, and most fundamentally, petitioner's claim to deference is irreconcilable with his categorical refusal to provide health care to respondent.[14] This is not a case in which a practitioner has sought, consistent with reasonable medical judgment, to modify his practices and procedures in order to minimize personal risk while still reasonably accommodating his patient's needs.[15] Petitioner's attempt

[14] The court of appeals noted that petitioner did not attempt to prove that the hospital treatment he proposed was significantly safer than routine office treatment, but instead claimed "the right to deny entirely routine dental treatment to patients with HIV." Pet. App. 16a n.4.

[15] There certainly will be cases in which a health care worker may seek to take additional precautions when treating a patient with a communicable disease; such precautions would be appropriate if they do not unduly burden the ability of the patient to get needed care and if they reflect a medically reasonable and good faith effort to accommodate the patient's needs as well as the health care worker's reasonable concerns for personal health and safety. In such a situation, there should ordinarily be no basis for a finding of discrimination, but that is not this case.

to defend his absolute position by appealing to the AMA's ethical principle that physicians shall be "free to choose whom to serve" (see Petitioner's Merits Br. 45 n.34, quoting AMA Principle VI) is misguided. The AMA's ethical opinions make clear that this broad principle is bounded by the ethical duty not to refuse treatment to patients on the ground that such treatment would pose some personal risk to the physician. See AMA, *Code of Medical Ethics* §§ 9.12, 9.131 (1996-97 ed.), AMA *Amicus* App. 1a-2a. Indeed, the duty to treat despite some personal risk is inherently a part of what makes medicine a profession rather than a commercial trade—it is "constitutive" of what it means to be a medical professional. See Ezekiel Emanuel, *Do Physicians Have An Obligation To Treat Patients With AIDS?*, 318 N. Eng. J. Med. 1686, 1686-87 (1988). If deference is due to a professional judgment, it can only be because that judgment was made consistent with the critical tenets that separate a profession from a trade. A judgment that conflicts with those tenets is necessarily not a "professional" one, and therefore cannot merit deference.

* * * *

To many in our society, HIV disease raises the specter of an irreversible death sentence, and a protracted and horrible death at that. Fear of contracting this disease can be so great that it provokes decisions based on misinformation and prejudice—and thereby leads to discriminatory conduct without medical justification. It is precisely for this reason that the Americans With Disabilities Act should be construed, in complete harmony with the dictates of medical ethics, to prohibit arbitrary limitations

on the access of an individual to health care because that individual is seropositive for HIV. Based on the overwhelming weight of scientific authority, the long-established standards of the medical and dental professions, and the manifest intent of Congress, respondent should not have been denied dental treatment in the dentist's office.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

MICHAEL L. ILE
LEONARD A. NELSON
KARLA L. KINDERMAN
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
(312) 464-4600

CARTER G. PHILLIPS
MARK E. HADDAD *
SIDLEY & AUSTIN
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 736-8000

JACK R. BIERIG
JOSEPH S. MILLER
SIDLEY & AUSTIN
1 First National Plaza
Chicago, IL 60603
(312) 853-7000

Counsel for Amicus Curiae
American Medical Association

* Counsel of Record

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APPENDICES

APPENDIX A

CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS AMERICAN MEDICAL ASSOCIATION

Opinion 9.12—Physician-Patient Relationship: Respect for Law and Human Rights. The creation of the physician-patient relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under preexisting contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI)

Issued July 1986.

Updated June 1994.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions With Annotations* 152 (1996-97 ed.).]

Opinion 9.131—HIV-Infected Patients and Physicians. A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that creates an identi-

fied risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating risk to patients. (I, II, IV)

Issued March 1992 based on the report "Ethical Issues in the Growing AIDS Crisis," issued December 1987 (*JAMA*. 1988; **259**: 1360-61).

Updated June 1996.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions with Annotations* 157 (1996-97 ed.).]

APPENDIX B

PRINCIPLES OF MEDICAL ETHICS I, II, IV & VI AMERICAN MEDICAL ASSOCIATION

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions With Annotations* xiv (1996-97 ed.).]